The Journal of the American Medical Association

Published Under the Auspices of the Board of Trustees

VOL. LXV, No. 26 CHICAGO, ILLINOIS DECEMBER 25, 1915

TROPICAL SANITATION IN ITS RELATION TO GENERAL SANITATION *

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As this evening I am speaking to health officers, I shall dwell more particularly on matters which have forced themselves on my attention during a lifetime spent in most active health work. From long experience, certain convictions have been gradually forced upon me as basic in all health work. These basic facts have not been generally recognized, as far as my experience goes. To make my argument clear, I shall run briefly over my own experience in this field.

The great awakening in tropical sanitation which has taken place in the last twenty years began with the Spanish-American War. For the last three or four hundred years it has been known by Europeans that military expeditions involving any large bodies of white troops could not be undertaken in the tropics on account of the great loss from disease. In the many cases in which such campaigns had been undertaken, they had failed on account of the loss of life caused by, and the disability due to, tropical diseases. These tropical diseases in the Western hemisphere were chiefly yellow fever and malarial fever.

It is astounding to the military sanitarian of the present day to read of the losses caused by yellow fever to military expeditions in the West Indies. One can hardly believe the loss reported as possible. The English Army in the Windward Islands in 1794 under Sir Charles Grey, out of a total strength of 12,000 men, lost 6,000. The French Army in Santo Domingo in 1798, out of a total strength of 25,000, lost over 22,000 from yellow fever. Again in 1802 the French Army in Santo Domingo, out of a total strength of 40,000, lost 20,000. Where it prevailed it was equally fatal to civil populations. Yellow fever has many times ravaged the United States, and still more severely affected Spain. In 1798 Philadelphia, out of a population of 20,000 inhabitants who remained in the city, lost 4,000. New York City, out of a population of 50,000 in 1798, lost 2,500. New Orleans, out of a population of 100,000, lost, in 1853, 8,000 of its citizens. Spain in 1800 lost 60,000 people from yellow fever, and again in 1804, 50,000. Barcelona in 1821, of a population of 70,000, lost 16,000. Gibraltar in 1804, with a population of 10,000, lost 6,000.

These figures give some idea of the disease in its bad form. Yellow fever, like syphilis, was an American disease and was not known to Europeans before the discovery of America by Columbus. The severity of yellow fever is such that it has prevented successful colonization by Europeans in countries where it can become endemic.

About the beginning of the nineteenth century it looked as if yellow fever was about to spread over the whole known world. If the manner in which yellow fever became epidemic in Spain is any measure of the manner in which it would affect China and India, some idea of these conditions can be imagined. About the middle of the nineteenth century the area affected by yellow fever began to decline, and it has since then continued to contract till at the present time it has almost become extinct.

All during the nineteenth century the United States was so frequently ravaged by epidemics of yellow fever, and so great loss of life and loss of wealth had been thereby brought about, that the people were willing to go to great expense or submit to drastic measures for the purpose of getting protection from the disease. It was very evident to sanitarians who had given any study to the matter that the epidemics which affected the United States were imported from the endemic focus, which had existed at Havana, Cuba, for the preceding 150 years. The United States was, therefore, very anxious to get rid of Havana as an endemic focus.

When we came into possession of this city in 1898, as a result of the Spanish-American War, every endeavor was made by the authorities to eradicate yellow fever. The whole attention and force of the government were centered on the effort to clean up the city. Yellow fever was then believed to be the best example of a disease caused by filth. In 1900, two years after our occupation, Havana was one of the cleanest cities in the world. But yellow fever was worse than it had been for several years. I, at this time, was health officer of the city under the military governor. The authorities were at their wits' ends and knew not what to try. The Cubans were very much inclined to poke fun at us and at our extraordinary ideas on the subject of sanitation.

I one day overheard a conversation on this subject between a Cuban man and his wife. A large tenement-house had been emptied of its inhabitants for the purpose of cleaning and disinfecting. The families were sitting around on their household goods in all degrees of discontent and irritation. Both husband and wife criticized the eccentric Americans very freely. The wife began to advance some extenuating circumstances — that after all the cranky Americans would leave their house clean and free from bugs. The husband took the ground that the Americans had a

* Address delivered at the Fifteenth Annual Conference of Health Officers of New York State at Rochester, Sept. 6, 1915.

right to be as cranky and clean as they wished as long as they applied it to themselves, but when they attempted to force their crankiness and their cleanliness on free-born Cubans things had gone entirely too far.

The Havanese population as a whole were very patient under our rigid sanitary measures. I shall always remember with kindness and affection their good natured attitude toward the sanitary department during the four years I spent in their midst as health officer of the city.

A distinguished physician of Havana, Dr. Carlos Finlay, had been maintaining for the previous twenty years that yellow fever was conveyed from man to man by a certain species of mosquito, the stegomyia. From the known facts with regard to yellow fever and from the life history of this species of mosquito, Dr. Finlay had reached this conclusion by a most logical and interesting argument. Dr. Finlay has died in Havana within the last month at the ripe old age of 82. He is one of the great men in medicine who lived long enough to see his work recognized.

The army board, consisting of Reed, Lazear, Carroll and Agramonte, took up in 1900 the investigation of the question of the transmission of yellow fever by the mosquito. They carried to conclusion one of the most mathematical demonstrations ever accomplished in medicine. They placed men out in the country near Havana, so guarded that it was impossible for them to contract yellow fever from their surroundings. They then took the female stegomyia mosquito, allowed her to sting men sick with yellow fever, and then bite the men in this camp. The men bitten developed yellow fever. They then took material soiled by yellow fever patients in every possible manner; had men sleep in rooms filled with this material for weeks at a time. No one contracted yellow fever in this way. They took the blood of yellow fever patients and injected it into well men. They developed yellow fever. They took the blood of a yellow fever patient and passed it through a filter that would stop any particle large enough to be seen by a microscope of the highest power. This filtered blood, when injected into the circulation of a well man, still gave yellow fever. They heated the blood of a yellow fever patient and then injected it into the circulation of a well man. The man did not develop yellow fever. They took the blood of a yellow fever patient who had developed yellow fever as the result of the hypodermic injection of blood from a preceding yellow fever case. This blood caused yellow fever in the man into whose circulation it had been injected. This board, as the result of their labors, published the following very important conclusions:

Yellow fever is conveyed from man to man by the bite of the female stegomyia mosquito, and, in Nature, is probably conveyed in no other way. The disease is not conveyed by fomites of any kind. The disease is transferred by a parasite circulating in the blood and not by a toxin. This parasite is too small to be seen by the highest powered microscope then in use, and is killed by being heated. The parasite lives in the blood of the patient only during the first three days of the disease, and, therefore, the mosquito can be infected only during that time. It takes from twelve to twenty days for the parasite to go through its development in the mosquito and pass from the stomach to the salivary glands of the insect. Therefore, the mosquito is harmless for the first twelve days after biting the man sick of yellow fever.

The sanitary department of Havana took these important announcements of this board, and worked out the measures whereby they might be made of practicable effect in our fight against yellow fever. We established a quarantine whereby all infected ships or persons coming into the harbor of Havana were cared for, and a system of inspection whereby all such persons coming in by land were looked after. Our inspectors also saw daily at Panama every individual liable to yellow fever. A yellow fever patient was so screened and cared for that the stegomyia could not bite him. The attempt was made to kill by fumigating all mosquitoes that might have become infected from each case. And, finally, the attempt was made to destroy all mosquito larvae breeding anywhere within the city limits.

In the long run we found the destruction of the larvae to be a measure of more importance than all the other measures put together.

We commenced our antimosquito work at Havana in February, 1901. The last case of yellow fever in the city occurred in September of the same year. Havana had been the great endemic focus of yellow fever for all the Northern hemisphere during the preceding 150 years. Since the extinction of yellow fever in Havana, fourteen years ago, this disease has practically disappeared from the Northern hemisphere.

In 1898 Sir Ronald Ross of the English army had demonstrated that malaria was conveyed from man to man by another species of mosquito, the anopheles. He and other workers had established much the same condition as to the transfer of malaria as I have just described with regard to yellow fever. It was evident to the sanitary authorities, therefore, that a very slight extension of the work against yellow fever ought to cover work against malaria. This has turned out to be the case. Malaria rapidly decreased with the inauguration of the antimosquito work, and has since become practically extinct.

In 1904 our government undertook the construction of the Panama Canal. On account of the success of the work at Havana, I was placed in charge of sanitation at Panama. I succeeded in getting a good many of the men who had acquired experience in the work at Havana to come to Panama. These men were of inestimable value not only in the active organization of the work, but also in stemming the tide of fear, discouragement and hopelessness which existed on the isthmus during the first two years of our work there. Many of you here can understand what a moral support it is to a health officer to have twenty-five or thirty loyal men behind him. These men had been through similar work at Havana and knew that we were bound to succeed if we could only hold on long enough and convince our superiors that we were on the right track. But for a period in 1905, when yellow fever was at its height, we found ourselves working among a panic-stricken population who believed that we were cranks and fools. Our superiors on the isthmus at this time had become affected by the prevailing panic and were reporting to the authorities at Washington that our work had failed and were asking that we be relieved, and that men more practical and sane replace us.

This report would have ended sanitary work at Panama along the lines of modern tropical sanitation had it been acted upon.

For two years succeeding this time we were given the loyal support of our superiors, and by the middle of 1907 the work was accomplished. The request for our dismissal was made by the commission in June, 1905. In September, 1905, the last case of yellow fever occurred in the city of Panama, and only one case has occurred in the Republic of Panama since that time. All health conditions rapidly improved, and soon the isthmus, as to health, would compare favorably with many parts of the United States.

The eradication of yellow fever and the control of certain other diseases was undoubtedly due to the special sanitary measures taken against these diseases. But these special measures could have had no effect on the general health conditions. For the last fifteen years I have given a great deal of thought to this matter. What did we do at Havana and Panama to cause the great general improvement in health conditions which took place shortly after our arrival at both places, and has since continued?

At Panama shortly after our arrival we increased the wages of the common laborers from 11 cents an hour to 20 cents an hour. This was nearly four times the wages of the laborers in the surrounding countries. He knew that every fourth man would die each year of diseases prevalent on the isthmus, and it took strong inducements to get him to come at all.

If we paid the citizen of a foreign country four times the wages he got at home, we naturally had to increase largely the pay of American citizens whom we wished to get to come to the isthmus. This caused a steady increase in wages all along the line. During 1904 and 1905 this increase of wages was going on all the time. Every time a prominent official died of yellow fever it would cause a stampede in the force. We would have to offer inducements to get the old men to come back and to get new men to come in the places of those who would not come back for any inducements. If yellow fever had continued, we would still be raising wages on the isthmus. This large increase in wages caused a great general improvement in all living conditions — more room to live in, better food and better clothing. I am satisfied that to this improvement in social conditions, caused by our high wages, we owe principally our extraordinary improvement in general health conditions. It is a health officer's duty to urge forward those measures in his community which will control individual diseases; but my long experience has taught me that it is still more his duty to take that broader view of life which goes to the root of bad hygiene, and do what he can to elevate the general social conditions of his community. This, my experience has taught me, can best be accomplished by increasing wages. Such measures tend at the same time to alleviate the poverty, misery and suffering which are occurring among the poorest classes everywhere in modern communities. At Panama we increased wages by edict of the government. But our government got this money by taxing the people of the United States. It would have been of little benefit to our laborers if we had increased their wages by 10 cents an hour and then taxed them by 10 cents an hour in order to raise this money.

Such would be the result in the United States if we attempted to increase wages here by edict of the government as we did in Panama. Such increase would be of no benefit to the laborer.

Natural, just and proper wages are just what each man produces, not a cent more or a cent less. We can look back in the history of our own country and see that this condition of affairs was approximated in the early settlement of the country. A man coming to this country would take up land for which he paid nothing, and his wages were all he produced on that land. After a while all the land is taken up and the next man who comes has to work for some one else. Later a great many more men come, and these men bid against each other for work, and thus force down wages. This has gone on in the United States, and in all other civilized countries, till at the present time all producers get much less than natural wages, that is, what they produce.

Can this unfortunate and undesirable condition of wages be rectified?

Suppose an area of land as great in extent, and as fertile in production as the present Mississippi Valley, should tomorrow rise from the bottom of the Atlantic Ocean off the coast of Long Island. Suppose the United States should own this island and offer it to its citizens under our present homestead laws. Thousands of the citizens of New York would flock there and take up this land. These wages would be natural wages. Each man would get all that he produced: this would be very much in excess of the wages now given in New York. All the poverty, sickness and degradation caused at present by low wages would be rapidly ameliorated. The man who was so fortunate as to be appointed health officer for this island would in a few years be able to publish the most astounding health reports.

It is entirely possible for us to raise from the bottom of the sea just such an island as I have described. In every town and county in New York a large part of the lands are unused or only partially used. If this large body of unused land could be brought into use, the effect on the health conditions of New York would be exactly the same as would be produced by raising the island I have described.

Can these unused lands be brought into use? If these unused lands were taxed to such an extent that the owners would have to use them to the fullest extent in order that they might pay the taxes, is there any doubt as to what the result would be? All unused lands would soon be utilized to their fullest extent. The only way of making any profit from them would be to so use them. It would be a very losing venture not to use them to their fullest extent.

I have been fortunate enough to labor as health officer in a field in which very great health results have been produced; but they would be small as compared with the health results which will be produced by securing for mankind natural wages. It stirs my enthusiasm to think of what glorious opportunities are before the young health officer just commencing life. I have spent my sanitary life killing tropical mosquitoes, and I hope have thereby benefited my fellowman. I would give a good deal to spend another sanitary life in the ranks of the coming generation of health officers doing my share in the fight that is on us, the fight for the greatest of all sanitary measures, natural wages.

Health, Social Service and Government.—The higher ethical standards and the broad humanitarianism which have developed among large masses of the people, in these recent years, demand that the health and socal service activities of the government shall be absolutely divorced from politics.—Governor Charles S. Whitman of New York.

THE HANDWRITING ON THE WALL*

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CLEVELAND

In the recent convention of the National Wholesale Druggists' Association, Mr. H. A. Hover of Denver, chairman of one of the committees, referred to the subject of "proprietary" and "patent" medicines in the following words:[1]

> I apprehend that sooner or later we will all be up against not only radical state legislation, but national legislation as well, and we might as well forestall drastic action and lend a guiding hand as to the character that legislation shall take on. We did it properly and successfully in connection with the legislation on narcotics, and we might as well see the handwriting on the wall in this case.
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> This is an important question, which involves over 50 per cent. of our business, and we do agree that there are certain abuses incident to the manufacture and distribution of proprietaries which have grown up and which involve a lot of remedies that we cannot consistently defend, and we might as well lend our aid and start to clarify the situation.

It is gratifying that the handwriting should be perceived by important commercial bodies — for the "patent medicine" business is, unfortunately, largely a commercial question.

This awakening of the drug trade to the "patent medicine" evil is a most welcome accession to the forces that are working for the protection of the people. In the past, it is true, individual voices have been heard in protest; but for many years the drug trade, wholesale and retail, has winked at these evils. Too often it has even encouraged them. The "patent medicine" business could never have reached its present vast proportions had it not been backed by the silent, and very often by the voiced recommendation of the drug trade. These proportions are, indeed, enormous. Mr. Hover presents statistics showing that proprietary and "patent" medicines constitute over half of the total sales of the wholesale druggist — a little more than all the standard drugs, sundries, appliances and the multitude of things that go to make up the stock of the ordinary drug store. The Commission on Proprietary Medicines of the American Pharmaceutical Association, in a report presented this year,[2] estimates that the number of "proprietary medicines" on sale in the United States is from 40,000 to 50,000, exclusive of any "own make" preparations with only local reputation.

While the drug trade has been a partner in the growth of this business, and must take its share of responsibility for the abuses, it should not be blamed unduly. Many of the evils arose insidiously and were practiced thoughtlessly. It is more profitable and more just to rejoice that the conscience of the trade is now awakening, and to extend every aid in the power of our profession to make this awakening effective. In particular, we should give credit to the American Pharmaceutical Association for bringing the issue squarely before the pharmacists. It remains to be seen whether the association and the pharmacists will follow up this first step: whether they are ready to lay the ax to the root of the evil, whether they intend merely to prune a few of the overluxuriant branches, or whether, finally, they will prefer to shut their eyes and minds to the logic of events, and let things drift.

Their problem is not an easy or simple one. At the first view, it might seem that they had a final remedy in their power: They need only refuse to handle "patent medicines," and these would practically go out of existence. So drastic an action, however, would not be supported by present public opinion. The very fact that these medicines have so large a sale shows that the public wishes to use them, and that the public must first be educated to their evils, before it will wholeheartedly countenance their suppression. In the long run, more can be accomplished by fighting against the specific evils of the "patent medicines," than by attempting to suppress "patent medicines" as a class.

The drug trade is wisely choosing this path, if its attitude is fairly reflected in the report of the American Pharmaceutical Association commission already referred to. This starts with a study of the various detailed problems involved. On the basis of this study, the commission has drawn up a set of provisional rules as minimum requirements for an honest "patent medicine." All of these are in the right direction. A frank critic, however, must concede that they scratch only the surface of the evil, and promise only a slight palliation, and not a cure. The real cause of the evil is only very lightly, one might even say rather tenderly, touched on by the commission; but a further report is promised; and it is to be hoped that this will deal with the fundamental matters more frankly. Yet the present report contains interesting material, and deserves careful reading in the original. Its main features, however, may be abstracted and discussed.

The commission first points out some of the weak points in the stock arguments against "patent medicines."

1. There is a contradiction in the claim, on the one hand, that "patent medicines" are nothing but everyday prescriptions — on the other hand, that they are dangerous and worthless. Their defenders are prompt to inquire "why a given mixture should be considered a valuable and efficient remedy when dispensed by or on the order of a physician, and dangerous and worthless when put up in a carton with a printed label and wrapper."

The contradiction is of course easily answered; in fact, the commission furnishes the answer under 4, below.

2. So far as pharmacists are concerned, it is pointed out that the condemnation of widely advertised "patent medicines" looks insincere when they recommend their "own make" preparations of similar character. They do, indeed, defend the latter as being "nonsecret." In fact, however, their composition is not often divulged to the purchaser. It might be added that "own make" preparations really conflict with the tendency of medical practice acts, and will eventually have to disappear when these acts are consistently framed and applied. For "own make" preparations would have practically no sale unless they were personally recommended by the vender; and the personal recommendation of drugs is nothing more or less than prescribing.

3. While disclaiming against proprietary medicines as a class, pharmacists have not hesitated to stock and sell them, and often to recommend them, individually. Physicians who own drug stores have not been any more consistent.

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* From the Pharmacologic Laboratory, Western Reserve University, School of Medicine.

1. Forty-First Annual Meeting of the National Wholesale Druggists' Association, stenographic report, in Oil, Paint and Drug Reporter, Oct. 7, 1915, p. 37.

2. Report of the Commission on Proprietary Medicines of the American Pharmaceutical Association, Jour. Am. Pharm. Assn., October, 1915, p. 1148.

4. Only minor emphasis has been placed on what the commission rightly considers the greatest evil of the "patent medicine" industry, namely, "the falsity and extravagance with which its products have been exploited." Every one must agree with the commission, that "this is the basic evil of the 'patent medicine' business and the point where it is most vulnerable, and an attack upon this evil needs no argument for its justification."

The commission goes on to say, "Numerous 'patent medicines' are mixtures which have some merit if properly applied in cases for which they are adapted; the evil is not in the remedies themselves but in the method of their exploitation."

This also is true as a theoretical proposition. The question that the drug trade itself must attempt to answer is precisely this: *Can "patent medicines" be properly exploited?* If so, how?

The commission next takes up the distinction between "proprietary" and "patent" medicines. This distinction, it rightly concludes, depends essentially on whether or not the drug is advertised to the lay public, directly or indirectly. A medicine that is so advertised is a "patent" medicine; while one that is advertised only to physicians is a "proprietary" medicine. The commission points out that if advertising to the laity were prohibited absolutely, the use of proprietary medicines, except under the direction of qualified physicians, would be reduced practically to zero.

The commission considers that the problems of proprietary drugs are being properly and sufficiently cared for by the Council on Pharmacy and Chemistry, and that there is no call for the pharmaceutical profession to invade this field.

The commission then goes into an extensive consideration of the various questions involved in the "patent medicine" problem. On the basis of this, it formulates a set of tentative declarations of minimum requirements which "patent medicines" should meet in order to render them safe in the hands of the general public. It is emphasized that these are only provisional and subject to modification. These rules are so important that it seems worth while to reproduce them, together with some critical and constructive comments.

MINIMUM REQUIREMENTS

1. *Prescription Fakes, Concealment of Proprietary Character.*—The preparation must not be named or advertised in such a way as to conceal its proprietary character and lead the purchaser to believe that it is a simple chemical or vegetable drug ordinarily purchasable in small quantities instead of a proprietary mixture or substance.

This is a protection against a common form of fraud. The rule may be endorsed as it stands.

2. *Methods of Marketing.*—The preparation must be one which is regularly offered to the public through the usual trade channels, i. e., through regular wholesale and retail dealers in ready-made medicines, and thus subject to inspection by the authorities charged with the enforcement of state food and drug laws.

This would facilitate official supervision, especially of intrastate trade, by restricting the sale of medicines to licensed dealers.

This will become of material benefit to the public, however, only if these dealers are made legally responsible for their merchandise, for instance, for any misrepresentation, damage caused by the medicine, etc. Mere "inspection" will not furnish much protection.

With this proviso, the rule may be indorsed.

3. *Alcohol Content.*—If the preparation contains alcohol, it must be sufficiently medicated to prevent its use as an intoxicating beverage, and in addition to this requirement, the proportion of alcohol present must not be greater than is properly necessary to hold in solution in permanently active condition the essential constituents of the preparation, and to protect the preparation against freezing, fermentation, or other deleterious change.

This aims to prevent the use of "patent medicines" as intoxicants. As stated in another part of the report, "it seems fair to assume that when the alcohol percentage of a mixture is far in excess of pharmaceutical requirements, it is for the express purpose of making a preparation that will serve as a substitute for beverage liquors,"

The rule, however, does not go far enough really to protect the public. The present internal revenue regulations cover practically the same field; but they have undoubtedly failed to abolish the abuses. This is easily understood, for it is impossible to lay down any hard and fast line as to when an alcoholic medicine is "sufficiently medicated to prevent its use as an intoxicant." No one doubts that medicines containing merely vegetable extractives, such as many bitters, tonics, female remedies, etc., are often taken as intoxicants, even when the consumer does not realize this. If they produce the effects of alcohol, they are intoxicants, even when they are not used to the extent of paralyzing the victim.

There is but one way of doing away with the abuse of alcohol under the guise of "patent medicines," and that is to prohibit absolutely its sale to the public in this form, for the manufacturer, since he does not know the consumer, cannot guarantee that his alcoholic preparations will not be abused intentionally, or that it will not create an alcohol habit.

The rule in its present form sounds well; but to accomplish its professed intent, it should read, "No preparation may contain alcohol."

4. *Content of Habit-Forming Narcotic Drugs.*—If the preparation is one which is capable of being used internally, whether recommended for internal use or not, it must not contain cocain, nor shall it contain opium or any of its alkaloids or their derivatives, in greater proportions than those specified in Section 6 of the federal law commonly known as the Harrison Act, and it shall also contain other active drugs in such proportion that the use of the preparation will not be likely to create a drug-habit, nor satisfy such a habit when previously existing.

This provision is well meant, especially the last clause, that any preparation containing a habit-forming drug must also contain other active drugs in such proportion as to make its use for satisfying the drug habit impossible. However, the same insuperable difficulty exists here as in the case of alcohol, namely, that it is impossible to draw a definite line. The way to abuse is still open, the occasion still present, just as it is in the Harrison Narcotic Law. Are not the frightful dangers of the opium habit greater than the possible benefits of the direct sale of opiates to the public—however much one may try to guard against these dangers? Is it really indispensable to the welfare of the public that disguised opiates should be on sale? What ailments are there that are really benefited by amateur treatment with opiates, and that could not be benefited as much or more in less objectionable ways?

5. *Remedies for Children's Use.*—If intended for administration to infants or children, the preparation must not contain cocain, or opium or its alkaloids, or their derivatives in any proportion whatever.

This merits unqualified indorsement. The only criticism is its restriction to infants and children. It should read: "The preparation must not contain cocain, opium, etc., . . . in any proportion whatever."

It may also be pointed out that Rule 5 would furnish little protection to children, so long as the sale of opiates, etc., is permitted by Rule 4. The same cough syrups, etc., are used for all ages.

6. *Activity of the Preparation, Cautions Against Misuse.*—The preparation must be of such character that it will not be liable to endanger life or health when used in accordance with the accompanying instructions, and if the preparation is one which is liable to occasion injury when improperly used or when used to excess, the accompanying literature must bear instructions tending to guard against such improper or excessive use.

This provision is intended to diminish the danger from toxic constituents. It may be indorsed, with the important addition, "All preparations which may occasion harmful effects, even when used improperly, must be plainly and conspicuously labeled POISON."

7. *Immoral or Illegal Purposes.*—The preparation must not be intended for use as an abortifacient or for use for any other immoral or illegal purpose, nor must it be advertised or recommended either directly or indirectly as an abortifacient or for any immoral or illegal purposes.

The advisability of this rule is self-evident.

8. *Incurable and Contagious Diseases.*—The preparation must not be advertised or recommended as a cure for diseases or conditions which are generally recognized as incurable by the simple administration of drugs, or for the cure of contagious or acute diseases the treatment of which properly requires the supervision of a qualified medical attendant.

This is the only rule to which the National Wholesale Druggists' Association took exception. It is stated in the stenographic report that the reasons for their adverse action will be transmitted to the commission; and it will be very interesting to have these published. On its face, the rule seems perfectly fair, and to the public interest. Theoretically, it is of course conceivable that some one might discover a drug cure for an incurable disease, and market this as a "patent medicine." Practically, the contingency is too remote for serious consideration. If such a discovery were actually made, the inventor should be required to prove that he has found a cure; and if he succeeded in doing so, the disease would no longer be incurable, and his medicine would therefore not come under the provisions of this rule. Experience has shown, however, that the requirements for this "proof" should be extremely stringent. The rule deserves indorsement as it stands.

9. *Conformity to the Federal Food and Drugs Act.*—Neither the label on the package nor any of the accompanying literature shall bear or contain any statement in conflict with the misbranding provisions of the Federal Food and Drugs Act.

This is self-evident.

10. *Advertising Not Accompanying the Package.*—Advertising not accompanying the package shall conform substantially to the statements on the label, carton, or in the accompanying circulars as to the origin, composition or character of the preparation, or concerning its curative or remedial value.

This rule is needed to check irresponsible advertising in the newspapers, circulars, etc., which are not readily reached by the present machinery of the law. The rule deserves indorsement; but the chances are that it would not be enforced, unless a rather elaborate machinery of supervision were provided.

THE SECRET FORMULA

Taking the rules as a whole, as they stand, there can be no doubt but that their enforcement would correct some of the flagrant "patent medicine" evils. As has been indicated, they could be modified so as greatly to increase their efficiency. Even then, however, they are merely so many plasters to the sore; and as with all kinds of superficial treatment, when we succeed in healing the sore in one place, it is apt to break out in another, until the disease itself is attacked. It is questionable, therefore, whether we are not simply wasting time by experimenting with legal plasters, instead of attacking the fundamental fault. What, then, is the spring of the "patent medicine" evil? Why is it that the makers of "patent medicines" have been able to deride all past efforts to correct their abuses? Why has it been possible for them to make exaggerated and false claims, such as could not be made in any other line of business? Why have they been able to sell poisons; to foster alcohol and drug-habits, to create imaginary disorders and to prevent the treatment of real diseases; to injure individuals and the community in health, happiness and purse? Why have they been beyond the efficient reach of law and of public opinion?

If the commission seeks a true answer to this question, it will find it in a single word, and in nothing else: *secrecy*. Until this is corrected, all rules and laws are more or less futile. So long as the composition of "patent medicines" is secret, it is impossible to make them subject to any efficient law. So long as the composition is secret, the manufacturer has every technical advantage — he is working in the light, the public in the dark. You may, it is true, try to meet his older tricks, one by one; you may succeed in making him name his poisons, narcotics or alcohol; you may even prohibit them — provided they are such as you can succeed in isolating from his complex mixture. You may legislate against his selling harmful preparations or making untrue claims, but to apply the law, you must prove your contention. Here secrecy is a strong, often perfect protection; for to prove the harm or disprove the claims of a complex mixture of unknown composition is a task of such magnitude as to frighten the average prosecutor out of the attempt. It would tax the resources of a large scientific and legal institute to bring a dozen of the plainest offenders to task, each year — the thousands of other offenders meanwhile basking in immunity. And then, the offender having paid his fine out of a day's or week's profit, need only spend five minutes in making up a new secret formula — and where is the profit to the public?

On the other hand, assume the composition published, and the task of the inspectors becomes, relatively, a pattern of simplicity. The composition can be checked, chemically, with infinitely greater ease, when the supposed ingredients are published. The claims can be checked much more simply when one can utilize the large amount of data that science has accumulated. The "patent medicine" business can be made to travel, as any honest business, on its merits, instead of its imagination.

The secret formula, then, is the key to the "patent medicine" evil. The commission does not appear to have perceived this clearly; at least, it has not made up its mind. It states that it is "by far the most delicate

and difficult" phase of the subject — doubtless so, because it is the crux of the situation — and wisely wishes to make sure of its ground before announcing a conclusion. The conclusion will be awaited with great interest, for by it the report of the commission will stand or fall; by it the thinking public will decide whether or not the commission places the public welfare above all other considerations.

There are at present three plans of dealing with the formula question: The first, to permit the manufacturer to keep the ingredients secret, as at present, except for certain specifically stated poisons. Second, the confidential registration of the formula with some government commission; this is the plan in force, or proposed, in England, Canada and New York City. Third, the publication of the formula on the label. By the latter is commonly meant the statement of the active ingredients and their quantities, without requiring the details of the working formula, flavors, menstruum, etc.

The arguments which are made by the opponents of the published formula are, that this would amount to confiscation of the property; that it would do no good to the consumer; and that the formula is no one's business except the owner's.

The real opposition, of course, arises from the apprehension that publishing the formula would hurt the "patent medicine" business. It is urged that the "patent medicine" manufacturers have spent large sums of money on advertising and creating a sale for their products; that, were their formula published, a host of imitators would arise who would claim to produce the same article; and who, having been spared the expense of advertising, could produce it at a lower price and thus drive the original manufacturers off the market. At first view, the argument appears quite reasonable; but on closer examination it is found to have some very weak features. In the first place, there are probably few druggists who do not consider themselves competent to imitate any "patent medicine" that is sold, even though its composition is supposed to be secret; at least, there are very, very few druggists indeed who do not think that they can produce something just as good, if not better. The cry against substitution, which we have heard for all these years, shows that secrecy has not protected against imitation.

It is most doubtful that the imitation would be any greater with the published formula than without it. It has never been demonstrated that the few "patent medicines" that do publish their formulas, such as castoria and the Ayer's preparations, are being imitated to any greater extent than the others. If the manufacturers are really serious in desiring protection against imitation, they could obtain this by patenting their formula — provided this is really original and meritorious — but there, perhaps, is the rub.

While it is not probable that the fears as to imitation need be taken very seriously, it is possible that publication of the formula would hurt the "patent medicine" business in quite another way: It would make it difficult, if not impossible, to advance the many extravagant claims of marvelous cures on which the "patent medicine" business is largely based. It would also undoubtedly greatly lessen the fictitious efficiency of the preparations in actual use. It might no longer be possible to remove or put on fat by the use of a little alum, washing soda or starch. The published formula would furnish a criterion of originality and efficiency, which many "patent medicines" could not withstand. Those that are neither original nor efficient would undoubtedly be hurt in their sale. It is doubtful, however, whether many outside of the "patent medicine" interests would shed tears over this danger. If a business is hurt by enforcing honesty, it is to the public interest that it should be hurt. In short, the publication of the formula would do but little harm, if any, unless there is the intention to defraud.

On the other hand, the published formula would be of some help to the honestly intentioned "patent medicine" manufacturers. In the first place, it would be the most efficient way of meeting the present feeling of the educated public against "patent medicines." As is pointed out by the American Pharmaceutical Association commission, a given "patent medicine" may be of more or less, sometimes considerable, use in suitable cases. The fundamental objection to "patent medicines" as a class is that it is impossible to judge whether any of them are suitable to any patient, when their composition is not known. The patient often asks his physician whether it is safe for him to continue a "patent medicine" that he has used with apparent benefit, or to try one that has been recommended to him. In such cases, a physician would usually have no objection to humoring the wishes of the patient, provided he could be certain that no harm would result. With the composition secret, it is impossible for him to be certain of the harmlessness. He must, therefore, unqualifiedly prohibit the use.

The second argument in defense is that the publication would do no good to the buyer, because he would not understand the formula anyway. This entirely underestimates the intelligence of the public. Some do understand, and others seek advice. There are very few who would try to remove their fat with a little alum at an extravagant cost if they knew that it was alum. It is rather suggestive that several state laws require the publication of the formula of stock remedies. It can scarcely be contended that the farmer knows something about what "salts" is when giving it to a horse, but has never heard of it when he takes it himself!

The publication will also be of some service to the public in protecting it against a change in formula whenever the price of ingredients advances, or when other reasons prompt the manufacturer. I do not know how often such changes are made, but there is a widespread belief that they are not uncommon. The purchaser is certainly entitled to know when the thing that he buys under a given name is different from what he had formerly bought under the name.

A final argument, and to my mind the most important, is the protection of the public against drugs which may under some circumstances be perfectly harmless, but which may become very harmful under other conditions. One need only remember the dire results that would follow the application of calomel to the eye of a patient who is taking iodid — a frequent constituent of "patent medicines" — without the knowledge of his physician. Perhaps even more common are the instances of oversusceptibility to the effects of drugs. In these cases the patients and their physicians are generally aware that this or that drug should not be used. There are no statistics to show how much damage is done by the consumption of "patent medicines" whose constituents are quite harmless for the average individual, but against which certain people react abnormally, and

which would be avoided if the consumer knew the constituents. On the other hand, the patient may not know their susceptibility, and finally consult a physician concerning an unusual, obscure and intractable train of symptoms whose cause and cure would be clear the moment that the physician knew the drugs that had been taken.

It may be argued, thirdly, that the formula is the property of the manufacturer, that the medicine is likewise his property, and that he can sell it under his own conditions. If he chooses to keep the formula secret, and the purchaser does not like this, he need not purchase and no harm will be done. If he does purchase, the transaction is strictly between him and the manufacturer, and the business of no one else. The fallacy of this "individual liberty" argument has often been pointed out. Logically, it would permit and legalize any sort of fraud. It is now universally conceded that where the public has not the means of judging for itself, the state can and should step in to afford it protection. A law requiring publication of the formula would still leave the formula the property of the manufacturer, and would not at all compel him to disclose it. Only, if he wishes to keep the formula to himself, the state will also oblige him to keep the medicine to himself.

The proposal to register the formula confidentially with a government body is a sort of middle ground that is supposed to guard the interests of the manufacturer, and protect the public against the grossest forms of fraud and the most marked dangers. As a matter of fact, it can do neither satisfactorily. It would not effectively protect the manufacturers, because the government commission — itself consisting of several individuals — would often need to call in outside advice to pass on the various claims, etc., made for each medicine, if it were to do its task at all conscientiously. One can easily see what chances there would be for the leakage of information. Once information had leaked, the much dreaded damage would have been done. Who would assess and pay the damages to the manufacturer?

It would not effectively protect the consumer, because a composition that might be harmless for most individuals might be harmful for him; a manufacturer might make claims which the government body might hold to be justifiable in the majority of cases, but which would not be at all justifiable in individual cases. The medicine might contain ingredients which are ordinarily not dangerous, but which become dangerous under certain conditions which the government body could scarcely foresee. The cost of the medicine might be so extravagant that the individual consumer might consider it as fraudulent; the government body would have great difficulty in drawing a line.

Let us not forget that a question is never settled until it is settled right; and that a settlement that is satisfactory to neither party is certainly *not* right.

After the American Pharmaceutical Association commission has formulated its final rules, it will still be confronted by the problem of making these effective. It may urge their enactment into laws; but until that can be accomplished, it must rely largely on the moral pressure that it can exert. Perhaps the "patent medicine" manufacturers will themselves see the light and aid in the reform. Or will they put themselves in the position of Belshazzar and his court and wait until sentence has been pronounced?

They drank wine and praised the gods of gold, and of silver, of brass, of iron, of wood, and of stone.

In the same hour came forth fingers of a man's hand, and wrote over against the candlestick upon the plaister of the wall of the king's palace; and the king saw the part of the hand that wrote.

Then the king's countenance was changed, and his thoughts troubled him, so that the joints of his loins were loosed, and his knees smote one against another.—Daniel, v, 4-6.

CARBOHYDRATE INDIGESTION

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Carbohydrate indigestion is not, strictly speaking, a disease, but a functional disturbance which may occur by itself, or as a complication of disease of the alimentary tract or of other parts of the body. Scattered references to faulty digestion of carbohydrates are to be found, under the headings "Gastric Ulcer," "Meteorism," etc., in the current textbooks on diseases of the stomach and intestines, but the subject is, so far as I am aware, nowhere treated as a comprehensive whole. Yet the condition is very common and responds readily to a proper regulation of the diet.

The discussion will be limited to carbohydrate indigestion in adults, since the condition as it affects infants forms a subject by itself.

There are distinct limits to the tolerance for carbohydrates, proteins and fats. These limits vary widely in different persons, and in the same person at different times. When the amount in the diet of one of these forms of food exceeds the limit of tolerance, then either disturbance of digestion, or of absorption, or both, is the result.

Indigestion of various kinds is perhaps more often due to a diet unsuited to the individual than to any other cause. The symptoms of carbohydrate indigestion are the result of fermentation, with the formation of various gases, carbon dioxid (CO_2) and methane, (CH_4) etc., and volatile fatty acids. For fermentation to take place three factors are necessary: (1) the presence of suitable micro-organisms; (2) a proper medium for them to work on, and (3) more or less stagnation of the contents of the stomach or intestine, in order that the organisms may have sufficient time for action. A great variety of organisms may give rise to gaseous fermentation, among which the yeasts and various bacteria are the most important. Kuhn and Strauss[1] have shown that hydrochloric acid does not inhibit the development of yeast cells. Gaseous fermentation is found in the stomach, according to Riegel,[2] especially in cases of dilatation, with normal or increased amounts of hydrochloric acid, though it may occur in the absence of hydrochloric acid. In the case of the intestines the colon is the chief seat of gas production, on account of the abundance of micro-organisms and the stagnation of the contents.

The exact causes of carbohydrate indigestion remain obscure. In the stomach, hyperacidity might be a factor by interfering with the action of the salivary diastatic ferment. In the large intestine the presence of undigested or partially digested starch is probably the most important factor, for sugars are invariably

1. Kuhn and Strauss: Quoted by Riegel in Diseases of the Stomach, Nothnagel's Practice, Am. Ed., 1903, p. 123.
2. Riegel: Diseases of the Stomach, in Nothnagel's Practice, Am. Ed., p. 403.

absorbed higher up in the canal. The micro-organisms are probably always present and only await a suitable opportunity for their activity.

The faulty digestion of starch in the intestine might be due to an insufficiency of the diastatic ferments, or, as A. Schmidt[3] suggests, to a defective digestion of the cellulose which forms the outer envelope of the starch cells, and must be removed to allow the digestive ferments access to the starch within.

SYMPTOMS

The symptoms of intestinal fermentation are chiefly those due to distention with gas. The patients in the milder cases complain only of a sense of fulness or discomfort coming on several hours after meals, and of flatulence. The higher degrees of tympanites are accompanied by colicky abdominal pain, which may be severe, and is relieved by the passage of gas. The seat of the pain varies according to the part of the intestine affected; it may be general, or located in the right iliac region, or the left side of the abdomen. Pain is more likely to occur if there are adhesions which are pulled on, as in the case of distention of the cecum with adhesions from chronic appendicitis. Sometimes the acid products of fermentation irritate the bowel to such an extent that diarrhea results, the so-called "fermentative dyspepsia," of Adolph Schmidt. The movements are then frequent, acid and foamy from the admixture of gas bubbles.

Gastric fermentation gives rise to distention of the stomach, which is relieved by belching. "Heart-burn" is another common symptom in this condition, and one that is relieved by diminishing the amount of carbohydrates in the food. Whether, however, the carbohydrate indigestion is secondary to the hyperacidity, or causes it by the irritating products of fermentation, remains an open question.

DIAGNOSIS

Since abdominal distention is the principal symptom of carbohydrate indigestion, it becomes necessary to consider all the causes of tympanites. These are four, namely, (1) increased gas production; (2) mechanical obstruction of the intestine; (3) the so-called paralytic ileus, or obstruction due to paralysis of the intestine, and (4) deficient absorption of gas from the intestines. Mechanical obstruction can only give rise to doubt in cases of chronic and partial obstruction; here a careful inquiry for previous inflammatory abdominal disease, and examination of the abdomen for tumor, visible peristalsis, and intestinal rigidity (*Darmsteifung*) will usually solve the question, though roentgenoscopy may be necessary before a final decision is reached. In paralytic ileus the symptoms are those of acute intestinal obstruction, usually associated with acute general peritonitis or following an abdominal operation. It is obvious that such a condition does not in the least resemble distention due to fermentation.

Tympanites from decreased absorption of gas is a rare condition, met chiefly in the aged, and presumably due to arteriosclerosis of the mesenteric vessels. The diagnosis can be made, with some reserve, in arteriosclerotic subjects with distention for which no other cause can be assigned.

After the exclusion of other sources of tympanites, that due to increased gas production remains. It is by far the commonest cause of distention. It may be the result of fermentation of either carbohydrates or proteins, but the carbohydrate fermentation is much the more frequent of the two. Therefore it will be allowable in a given case to limit the carbohydrates in the diet, and base the diagnosis on the results of treatment. A more certain opinion, however, can be reached by the examination of the feces. The reaction is perhaps the best single guide, an acid stool pointing to the carbohydrates, and alkalinity to the proteins, as the element at fault. The presence, under the microscope, of undigested starch granules, as shown by the iodin test, is additional evidence of carbohydrate indigestion, while a foul odor points with certainty to the putrefaction of proteins. The presence in the urine of large amounts of indican, or phenol, or both, also indicates increased protein decomposition. The fermentation test of Schmidt[4] is useful, though seldom indispensable. It consists in measuring, by means of a simple apparatus, the gas produced by a definite amount of feces when incubated for twenty-four hours in a thermostat, the reaction being taken before and after incubation. If the reaction becomes more acid, the fermentation involves the carbohydrates, if more alkaline, the proteins.

The fermentative diarrhea of Schmidt is easily recognized by the examination of the stools, which are mushy, acid, mixed with bubbles of gas, and contain undigested starch. Though the movements are increased in number, it is not, strictly speaking, a diarrhea, for the water content is not increased.

When belching is the principal symptom it is necessary to determine whether the gas is swallowed, or formed within the stomach. Cribbing, or the swallowing of air, is to be suspected when there is a history of a very large amount of gas brought up within a short space of time. On watching the patient, swallowing movements may be noted at frequent intervals, and the belching will be prevented by the wearing of a piece of cork between the teeth. If the gas is formed within the stomach, it may be due to simple carbohydrate indigestion or be secondary to obstruction of the pylorus or atonic dilatation of the stomach. The latter conditions may be distinguished by the use of the stomach pump, and of the Roentgen ray. Belching in a fat person is always suspicious of carbohydrate indigestion, for serious disease of the stomach almost always leads to loss of weight.

TREATMENT

The treatment of carbohydrate indigestion is mainly dietetic. It consists in a marked reduction of the total carbohydrate intake, with exclusion of certain articles which are known to undergo fermentation readily. Such are potato, sweet potato, cabbage, beans (except string beans), and chestnuts. The harmfulness of potato in this connection is possibly explained by the work of Lang,[5] who found, in the course of experiments with pancreatic diastase, that potato, though easily changed to achroödextrin, is very slow to undergo the further change into sugar. In obstinate cases, particularly in the fermentative diarrhea of Schmidt, it may be necessary to resort for a while to a strict protein-fat diet, consisting of eggs, meat, fish, bouillon, butter, and tea or coffee with milk or cream. According to Schmidt, a small amount

3. Schmidt, A.: Klinik der Darmkrankheiten, p. 199.

4. Schmidt, A.: Klinik der Darmkrankheiten, p. 100.

5. Lang, S.: Ztschr. f. exper. Path. u. Therap., 1910, viii, cited in v. Fürth, Problem. d. phys. u. path. Chem., ii, 216.

of cane sugar and fruit jellies may be taken in addition to the above. After a few days of such a diet, carbohydrates may be added cautiously, one at a time; sugar, cream of wheat, toast or zwieback, macaroni, and rice, in the order named. Potato is best left out of the diet for a long time. In cases without diarrhea, vegetables of low carbohydrate content, such as carrots, turnips, squash, egg-plant and string beans, are well tolerated from the first. They should be sieved and served with butter.

If obesity is present, a reduction in the total caloric value of the food should be combined with the limitation of carbohydrates. The relief of indigestion is often a welcome by-product of an obesity cure.

The results of the dietetic treatment of carbohydrate indigestion are most gratifying, dyspepsia of long standing disappearing in a few days. In fact, if relief is not obtained, it is probable that the diagnosis is wrong and some other condition is present.

The drug treatment of fermentation will accomplish little by itself. When combined with regulation of the diet it sometimes seems to be of benefit, but as a rule it is superfluous. The drugs most likely to give relief are the various salicylate preparations and beta-naphthol. Belching can be facilitated by the administration of the ethereal oils, such as peppermint, or menthol in half-grain doses. Diastatic preparations are occasionally of service.

The following cases, all of which occurred in private practice, may serve to illustrate the foregoing statements.

Case 1.—M. M., an unmarried woman, aged 67, was first seen Oct. 1, 1914. Her past history was not remarkable except for a tendency to nervous prostration. She had suffered from indigestion all her life, usually in attacks lasting from two to six weeks. The chief symptom had been distention with gas, coming on two or three hours after eating, and causing a good deal of distress, sometimes enough to keep her awake at night. When very uncomfortable she resorted to enemas to remove the gas. The physical examination was negative except for gurgling on palpation over the intestines. The feces were neutral in reaction, and were negative microscopically except for an excessive number of yeast spores. The treatment consisted in a protein-fat diet, with a small amount of carbohydrate in the shape of sieved green peas and apple sauce. A powder containing beta-naphthol, soda and bismuth was given after meals. The result was prompt relief. Three weeks later she reported that there had been very little gas, though she had left off the medicine some time before. Fruits once a day, nuts and ice-cream were then added to the diet. At her next visit, November 6, she was feeling very well. She was told she could eat rice, and after December 3, all vegetables except potato. She reported by letter July 7, 1915. In the spring she had two short periods of indigestion lasting two days or less; since then she has been free from symptoms except an occasional feeling of abdominal discomfort.

Case 2.—Mrs. D. K., aged 43, was seen Jan. 14, 1915. Her past history was negative. For the past eleven years she had had frequent pains in the left iliac region associated with distention. There was a constant dull pain there, with acute exacerbations in which the pain radiated upward toward the left costal margin. Examination showed a moderately obese woman, weighing 160 pounds; the viscera were negative except that the sigmoid was palpable. The feces were slightly acid in reaction, and showed a few undigested starch granules. On a diet low in carbohydrates she was soon relieved, and on February 3 reported that she had had pain only once in the last fortnight. During the following week she had no pain. On inquiry, June 26, 1915, she stated that she had been free from pain on a slightly restricted diet, except for a few occasions when she had taken more carbohydrate than usual.

Case 3.—Mrs. R., aged 56, had been getting stouter for two years owing to lack of exercise following the death of her pet dog. There was a good deal of heart-burn and gas in the stomach. Under a simple antiobesity diet these symptoms promptly disappeared.

Case 4.—This patient was a very fat cook who complained of incessant belching. The appetite was good but she was afraid to eat on account of the distress afterwards. Complete relief followed restriction of the carbohydrates and of the total food intake.

Case 5.—C. C., a college professor, aged 48, complained of distention from gas after meals, especially if he used his eyes directly after dinner. Examination showed slight obesity, and the abdomen somewhat distended. The stool was slightly acid, and contained many gas bubbles, and undigested starch granules. The treatment consisted of a mild reduction cure with low carbohydrates. A week later he reported that since changing his diet he had not been at all annoyed with indigestion. Carbohydrates were gradually added to the diet without a return of the symptoms. On inquiry six months later he said that he had remained well though on an ordinary diet.

Case 6.—This case illustrates the so-called fermentative dyspepsia of A. Schmidt. Mr. S., aged 53, had been under treatment for the past few years for vague neurasthenic symptoms and for chronic prostatitis. He complained of diarrhea of three months' duration. The stools were two or three a day in number, and were mushy, not watery. Examination showed a rather stout man, with nothing remarkable except the character of the stools; these were brown, soft, not formed, full of gas bubbles. Microscopic examination showed numerous undigested starch granules. He was put on a protein-fat diet consisting of eggs, meat and butter, with a small amount of carbohydrate in the shape of gluten-biscuit and tomatoes. No drugs were prescribed. A week later he reported considerable improvement, the bowels moving only once or twice daily, the stool partly formed. He was told to add three slices of toast to his diet, and to take a teaspoonful of a diastatic ferment preparation after meals. During the following week the movements dropped to one a day, and became formed and of normal appearance. Carbohydrates were restored gradually to the diet list and no relapse took place.

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ACTIVE IMMUNIZATION WITH DIPHTHERIA TOXIN-ANTITOXIN

AND WITH TOXIN-ANTITOXIN COMBINED WITH DIPHTHERIA BACILLI — SECOND PAPER: LATE RESULTS *

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The property of diphtheria toxin-antitoxin mixtures to produce immunity in animals has been known for a number of years. Successful results have been obtained in the immunization of horses (Park, 1902), goats, guinea-pigs, etc. Theobald Smith suggested the immunization of children by this method, but no one undertook it until 1912, when von Behring made the attempt.

In May, 1913, von Behring[1] reported the results obtained in human beings with mixtures of diphtheria

* Read before the New York Pathological Society, Oct. 13, 1915.
* From the Research Laboratory and the Willard Parker Hospital, New York City Department of Health.

1. Von Behring, E.: Ueber ein neues Diphtherieschutzmittel, Deutsch. med. Wchnschr., 1913, xxxix, 873.

toxin-antitoxin. The combined substances were either neutral or slightly toxic to the guinea-pig, but the definite proportions of toxin and antitoxin were not stated. The early reports of von Behring and his co-workers[2] were so favorable that we determined to make a similar attempt at the Willard Parker Hospital. The scarlet fever pavilion offered us exceptional opportunities to determine the efficiency of this prophylactic treatment against diphtheria.

Mixtures of diphtheria toxin and antitoxin were accordingly prepared in such proportions that they were either overneutralized (50 per cent. of the L + dose of toxin to each unit of antitoxin), just neutral (from 66 to 70 per cent. of the L + dose of toxin to each unit of antitoxin), or slightly toxic to the guinea-pig (from 80 to 90 per cent. of the L + dose of toxin to each unit of antitoxin).

Several series of patients were injected with these mixtures during the past two and one half years. Our first communication[3] in September, 1914, gave the results which we had obtained within from four to six weeks after the injections of toxin-antitoxin. From the available results at that time we concluded that the cases injected could be divided into two sharply differentiated groups:

1. Those who had a natural antitoxic immunity produced a very decided increase in the amount of antitoxin after injections of toxin-antitoxin. The response was very prompt and followed even after a single injection. These individuals were, however, naturally immune even before the injections, and needed no further immunizing injections.

2. Those who had no natural antitoxic immunity and were therefore probably susceptible to diphtheria gave entirely different results. An early response (within from four to six weeks after the injections) to the active immunization was noted in only 25 to 30 per cent. of the injected individuals. The examination of the blood serum of these patients for antitoxin showed the presence of from one-tenth unit to 10 units per cubic centimeter. Among those who did not definitely respond, however, a number gave a fainter Schick reaction[4] than the control test made before the injections of toxin-antitoxin. This showed that at least a trace of antitoxin had developed in the cells and had accumulated in the blood. This was not sufficient, however, to suppress the Schick reaction. When we retested these individuals from six to eighteen months later, a large proportion now gave a negative Schick reaction and were thus found to have finally become immune.

This late development of antitoxin is interesting in connection with observations which we had made with the Schick test in patients who had had diphtheria some weeks previously. Among these we noted that fully two thirds still gave a positive reaction, thus indicating in these a failure to develop an antitoxic immunity within the period noted after one attack of the disease. These figures correspond closely with the ones showing the early results of active immunization with toxin-antitoxin. An interesting observation, however, was made in this connection when our chronic tube cases were tested who had had diphtheria eight months or more previously. Nearly all gave a negative Schick reaction. This may have been due to a late development of antitoxin or to the fact that the cells only slowly yielded up to the blood the antitoxin formed in small amount soon after the infection. A few of these patients may have been subject to recurrent infections with the diphtheria bacillus. There was, however, no proof of this. In a group of four cases, for instance, in which a positive Schick reaction had been shown after an attack of laryngeal diphtheria, the gradual development of a permanent antitoxic immunity could finally be traced during the succeeding twelve months. In another patient, who had developed an immunity soon after the disease, a persistent negative Schick reaction was obtained during the entire period of observation.

These suggestive findings led to the conclusion that, while the immediate results of attempts at active immunization with toxin-antitoxin were disappointing, later ones obtained by retesting the immunized individuals without further injections might give a much better showing. We therefore determined to follow up and retest, from four to eighteen months after discharge from the hospital, as many of the injected children as possible. This tardy development of immunity in man is not unexpected, for it is a well-known fact that immunization of certain animals, like guinea-pigs, with diphtheria toxin alone or with the toxin-antitoxin mixture, is a slow process. It almost seems that in some persons there is not only the absence of antitoxin but also some substance which destroys the first traces of antitoxin entering the lymph and blood so that some time elapses before an excess of antitoxin becomes apparent in the circulating blood. The considerable success already noted of the tests of persons, some months after the toxin-antitoxin injections, led us to continue the work, and also to vary somewhat the methods employed with the hope of getting even better final results. As is well known, diphtheria has shown during the past decade little decrease in morbidity; the mortality of the disease, however, has been greatly lowered by the early administration of antitoxin. The problem, therefore, of an efficient method of active immunization in schools, asylums, hospitals and in the homes remains of great importance. By means of the Schick test we can detect the susceptible individuals, and control in a simple and yet accurate way the results of the active immunization.

The individuals who were retested with the Schick reaction to determine a late development of an antitoxic immunity can be divided into three groups. The

2. Following is a list of these reports:
Hahn, B.: Ueber Antikörperbildung bei Diphtherie, Experimentelles, und Klinisches, Verhandl. d. Deutsch. Kong. f. Inn. Med., Wiesbaden, 1913, xxx, 460.
Schreiber, E.: Zur Prophylaxe und Therapie der Diphtherie, Deutsch. med. Wchnschr., 1913, xxxix, 928.
Zangmeister, W.: Dritte Mittheilung über von Behring's neues Diphtherieschutzmittel, Die Anwendung des neuen Diphtherieschutzmittels in der Marburger Frauenklinik, von Behring. Anhang, Deutsch. med. Wchnschr., 1913, xxix, 977.
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early results in Groups 1 and 2 may be summarized in Table 1.

In Group 1, sixty-eight patients were actively immunized. No Schick reactions were made at the time, but for the sake of uniformity the results are stated in terms of positive or negative reactions. The patients in this group were bled before and after immunization

TABLE 1.—EARLY RESULTS IN GROUPS 1 AND 2

Persons Injected	Reactions	About Four Weeks Later	Number Developing Diphtheria
Group 1.....68	44 —	44 —	0
	24 +	6 —	0
		18 +	5
Group 2.....50	50 +	20 —	0
		30 + or ±	17

In this table, — = no reaction to toxin, and indicates presence of antitoxin; + = marked reaction to toxin, and indicates very little or no antitoxin; ± = moderate reaction to toxin, and indicates slight amount of antitoxin.

and the results determined by the examination of the serum for its antitoxin content.

Of the sixty-eight patients in Group 1, forty-four had natural antitoxin, and all gave a decided increase in antitoxin content after the injections; none developed diphtheria. Of the remaining twenty-four patients who had no perceptible natural antitoxin, six gave rise to antitoxin production, while eighteen failed to respond. Of the six no one, and of the eighteen five developed clinical diphtheria.

Since the crucial value of the treatment lay in its efficiency to protect the susceptible individuals, we selected for immunization in Group 2 a larger series of cases which had no natural immunity, as shown by blood examination for antitoxin and by a positive Schick reaction. Of the ninety injected patients, twenty responded to the injection of toxin-antitoxin with the production of sufficient antitoxin to protect

TABLE 2.—EARLY AND LATE SCHICK TESTS IN GROUP 2

Number Retested	Within Four Weeks	One to 1½ Years Later
16 +	5 —	5 —
	11 +	6 —
		4 ∓
		1 ±

In this and the following tables, — indicates negative Schick reaction, ∓ faint, ± moderate, and + fully developed Schick reaction.

against diphtheria; seventy failed to respond, though some gave a fainter Schick reaction than they had shown before the immunization. Among the twenty, no cases of diphtheria developed; of the seventy who produced very little or no antitoxin, seventeen developed clinical diphtheria twelve days and more after the first injection.

From Group 2, sixteen cases were subsequently retested from one to one and one-half years after the injections of toxin-antitoxin (Table 2).

Five of the sixteen who had shown an early and decided production of antitoxin again gave a negative Schick reaction. Of the eleven who had failed to respond at first to the immunizing injections, six now gave a negative, four a very faint and only one a positive Schick reaction.

Group 3 consisted of 158 patients (Table 3) who had originally given a positive Schick reaction. These patients were immunized with a mixture of toxin-antitoxin and a vaccine made of killed diphtheria bacilli. Three or four subcutaneous injections were given at intervals of from three to four days, each injection consisting of 1 c.c. toxin-antitoxin (85 per cent. L + dose of toxin to each unit of antitoxin), and 1,000,000,000 bacteria. One c.c. of the mixture injected subcutaneously into a guinea-pig produced a slight local induration and paralysis in ten days.

Local and general reactions were noted in about half of the injected individuals. They were, as a rule, more frequent and more marked in the older children and in adults than in the young children. These reactions are due in part to the slight excess of free toxin, and in part to the protein substance of the diphtheria bacilli; the more toxic mixtures will give, however, more severe reactions.

Local reactions consisted of pain, redness, some induration and local tenderness at the site of injection. The lymph glands in the axilla were not involved. Gen-

TABLE 3.—EARLY RESULTS IN GROUP 3 (158 CASES) WITH NO ANTITOXIN (+ SCHICK) BEFORE IMMUNIZATION

Number Injected	Within Four Weeks	Number Developing Diphtheria
158 +	56 —	0
	9 ∓	0
	83 ±	0
	10 +	4

eral reactions consisted of a temperature between 100 and 102 F. and slight malaise. The local signs appeared within twenty-four hours, lasted for another twenty-four hours, and then gradually disappeared. The temperature continued, as a rule, only for one day; in some, for two days. In no case have any serious effects appeared.

Of the 158 injected patients, fifty-six, or 35.5 per cent., produced enough antitoxin within four weeks to give a negative, and 9, or 6 per cent., a very faint Schick reaction. Of those who were partly or totally refractory, eighty-three, or 52 per cent., gave a moderately positive, and ten, or 6.5 per cent., a strongly positive Schick reaction. Of the ten, four developed clinical diphtheria.

To note any late development of immunity, we retested, from two to five months after the injections, fifty cases of this group (Table 4).

Ten of the patients who had given a definite early production of antitoxin continued to show a negative Schick reaction. Of the thirty-six patients who had produced only a trace of antitoxin, sufficient only to inhibit slightly the Schick reaction, twenty-six now

TABLE 4.—EARLY AND LATE SCHICK TESTS IN GROUP 3

Number Injected	Within Four Weeks	Two to Five Months Later
50 +	10 —	10 —
	36 ±	26 —
		4 ∓
		6 ±
	4 +	4 —

gave a negative, four a very faint and six a moderately positive reaction. The remaining four who showed no antitoxin production at first, now gave a negative Schick reaction.

Grouping together the early and late successful results in this series of cases, we find that forty out of fifty susceptible individuals had developed an anti-

toxic immunity after the injections of toxin-antitoxin plus vaccine. The remaining ten gave a reaction which was moderately positive in six and faintly positive in four cases. These cases probably had also developed some bactericidal immunity from the bacilli injected.

In addition to these, we also immunized with toxin-antitoxin a series of sixteen normal children (Group 4) who had given a positive Schick reaction. These children were injected about a year ago, and retested with the Schick reaction four and eight months after the immunization (Table 5).

TABLE 5.—EARLY AND LATE SCHICK TESTS IN GROUP 4 (NORMAL CHILDREN)

Number Injected	Within Four Weeks	Four Months Later	Eight Months Later
16 +	4 —	4 —	4 —
	10 +	5 —	5 —
		5 +	4 —
			1 +
	2 ±	2 —	2 —

Within four weeks after the injections, only four, or 25 per cent., gave a negative Schick test. Four and eight months later, these four still gave a negative reaction, thus indicating a probable lasting immunity. Ten children who produced no antitoxin at first now showed the following interesting results: At the end of four months, five gave a negative and five a positive Schick reaction. At the end of eight months, nine showed a negative Schick reaction and only one was still positive. Two of the sixteen children who had given a partial early response were found immune at the end of four and eight months.

Sixteen months later, eight of the actively immunized children were retested: Seven of those, who had become immune at the end of eight months, were found to be still protected, while the one who proved resistant again gave a positive Schick reaction.

In the same institution, we also retested after sixteen months a number of normal children who had not been injected with toxin-antitoxin. Table 6 gives the results of all the retests.

The table shows that of fourteen negatively reacting children between the ages of 5 and 15 years, when retested after sixteen months, two gave a positive, but twelve still showed a negative reaction. Of eighteen originally positive Schick cases, three were now negative while fifteen were still positive. It is interesting to compare with these eighteen the group of eight children who had been actively immunized with toxin-antitoxin; their retests showed that a much larger proportion had become immune than could be accounted for by the time factor alone.

TABLE 6.—RESULTS OF ALL RETESTS

Date	Not Immunized		Immunized
June, 1914	14 —	18 +	8 +*
October, 1915	12 —	3 —	7 —
	1 +	15 +	1 +
	1 ±		

* Toxin-antitoxin.

From the retests in the naturally immune children in this series and in a larger one at present under observation by us, the rather important fact may be deduced that a great majority of children of school age, who show a negative Schick reaction, probably remain protected for years, and even for life. Such persistent immunity, as shown with the test, could be successfully utilized in schoolchildren. During an outbreak of diphtheria among children previously tested, it would be necessary to immunize with antitoxin only the susceptible children. Class work could then continue without interruption.

Our results in active immunization up to the present time have led us to the conclusion that, while the toxin-antitoxin injections cannot be depended on to prevent diphtheria in the presence of immediate danger of infection because of the slow development of immunity in a majority of the cases, yet the injection is of value in rendering a community or school population immune to the danger of infection from future exposure up to a period of possibly several years.

The Research Laboratory will supply those connected with institutions, who are interested in the subject of active immunization against diphtheria, and are willing to furnish us a report of the cases, diphtheria toxin for the Schick test and a mixture of diphtheria toxin-antitoxin for immunization.

The reports should include:

1. The character of the Schick reaction before the injections and at the following intervals after the last injection: three weeks, six weeks, three months, six months, one year and two years. Pseudoreactions are to be carefully controlled.

2. The number of injections made. The dose recommended is 1 c.c., injected three times at intervals of seven days. The injections are made subcutaneously in the arm over the insertion of the deltoid. The dose is the same for individuals from 1 year to adult life. Infants below the age of 12 months receive 0.5 c.c. with each injection.

3. The character of the local and general reactions, if any, after each injection.

4. A description of the clinical cases of diphtheria which develop among the injected individuals during the course of immunization or afterward. Culture reports for the Klebs-Loeffler bacillus, etc.

5. Where possible, a quantitative estimation of the amount of antitoxin developed as a result of immunization.

The following groups of individuals are recommended for active immunization (only positive Schick cases to be injected):

(*a*) Children in schools and orphan asylums.

(*b*) Mothers and infants in lying-in places.

(*c*) Physicians, nurses and ward workers in contagious disease hospitals.

(*d*) Patients in general and contagious disease hospitals.

CONCLUSIONS

1. Individuals who, before treatment, give a negative Schick reaction are immune probably for life and, therefore, it is not necessary to inject them, when exposed, either with antitoxin or toxin-antitoxin.

2. Those who give a positive Schick reaction and are exposed to diphtheria and in immediate danger should receive either antitoxin alone or, if a longer protection is desired, both antitoxin and toxin-antitoxin.

3. For the general prophylaxis against diphtheria in schools and communities, excluding immediate contacts, a mixture of toxin-antitoxin alone (from 85 to 90 per cent. of the L + dose of toxin to each unit of antitoxin) or toxin-antitoxin plus vaccine of killed diphtheria bacilli is recommended. The dose is 1 c.c. of toxin-antitoxin and 1,000,000,000 bacteria injected

subcutaneously and repeated three times at intervals of six or seven days. Sufficient time has not as yet elapsed to judge the value of adding the injections of the bacilli to the toxin-antitoxin.

4. The early and the late results of active immunization should be determined with the Schick test. Early results are those obtained by the application of the test within four weeks, and late results from four months to two years after the immunizing injections.

EFFECT OF MODERATE DOSES OF SOME OPIUM DERIVATIVES ON GASTRO-INTESTINAL TRACT OF MAN *

PRELIMINARY REPORT ON ROENTGEN STUDIES

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This work was undertaken as the result of the observations of one of us (Pancoast[1]) on the gastro-intestinal motility of a patient who had a hypodermic of morphin several hours before the Roentgen studies were made. There was found not only an hour-glass constriction of the stomach, but also a striking retardation of the motility of the small intestine. Control studies on this patient at a later date, and when freed from the influence of morphin, revealed no such abnormalities.

The earliest investigations in which the Roentgen rays were utilized in the study of the action of opium and its derivatives on the gastro-intestinal tract were those in which animals, especially dogs and cats, were utilized. These studies frequently revealed, not only a retention of the bismuth meal in the esophagus for a period of one-half hour, but also a retention, even for hours, in the fundus and not the pylorus of the stomach, owing to a constriction in the region of the pyloric antrum. Intestinal motility was less influenced than gastric, and that of the large intestine less than the small (Magnus[2]). Later studies were made on the action of magnesium sulphate and colocynth with succeeding observations on the effect of morphin and opium administered shortly after the above-mentioned cathartics. Magnesium sulphate caused a delay in gastric motility, but an acceleration of motility of the small intestine and colon, while morphin was found to check this activity only by means of further delaying the passage of the meal from the stomach to the bowel. Colocynth produced first an increased gastric motility and then a delay. The motility and secretion of the small intestine and the motility of the large was increased. Morphin and opium checked the diarrhea by checking the activity in the small and large bowel, the tincture of opium being especially active in lessening the watery exudation (Padberg[3]).

The work of Müller and Saxl,[4] in which the capacity of the stomach of dogs was estimated, not by the roentgenogram, but by a gastric fistula and the introduction of varying amounts of water, showed that the capacity was almost doubled in narcotized animals, morphin being especially effectual, then chloroform, then chloral hydrate and finally local anesthetics, as anesthesin. Atropin produced a moderate relaxation, while epinephrin was ineffectual.

More recently a few studies have been made of the influence of the opiates on the human gastro-intestinal tract as revealed by the roentgenogram. Morphin was given by mouth and subcutaneously in varying doses. In some instances, small doses increased peristalsis in the pyloric region, while moderate doses caused a constriction of the pyloric sphincter and occasionally an hour-glass constriction. With large doses, the results were even more pronounced. Very similar results were derived from the tincture of opium (van den Velden[5]).

In nervous diseases of the "vagal neurosis" type, small doses were ineffectual. Moderate doses, especially in young, nervous females, caused a prolongation of the emptying time of the stomach. The emptying time of the small intestine was prolonged in all cases (Arnsperger[6]). Stierlin and Schapiro,[7] after similar studies, emphasize the influence of moderate doses of morphin on the retardation of the emptying time of the stomach in young people, in contrast to that of adults, the latter frequently being uninfluenced. In two cases of hypermotility, the emptying time was more rapid after morphin. In over half of their series, the motility of the small intestine was retarded while the large intestine was but slightly influenced. In chronic diarrheic enteritis, opium was found to retard the hypermotility of the small intestine.

Quite recently, the roentgenogram has been used in the study of gastro-intestinal motility following the administration of various purgatives, the more important observations being those of Meyer-Betz and Gebhardt,[8] who used senna, jalap, calomel and salines, and Katsch,[9] who gave atropin, pilocarpin and epinephrin.

We realize that our work so far is very incomplete, and this is offered only as a preliminary report on a subject we hope to follow and cover more conclusively during the next year. It is based on careful examinations of twelve persons, including the one previously reported, to whom morphin was given, and one drug habitué who was permitted to resume the use of heroin for one day. It has been possible to study these cases only when time would permit during the infrequent less busy intervals of full clinical and Roentgen laboratory hours. Moreover, the cost of such research is a factor that has to be carefully considered. Our studies have required 157 fluoroscopic examinations and the making of 170 roentgenograms.

With the exception of the heroin case, a control series of examinations was made to check up each drug series at exactly the same intervals. The corresponding plates were then studied side by side, together with the fluoroscopic notes. We fully realize that

* From the Roentgen Laboratory and Medical Wards of the Hospital of the University of Pennsylvania.

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4. Müller, A., and Saxl: Der Einfluss von Arzneimitteln auf Tonus und Kapazität des Magen, Verhandl. d. deutsch. Kong. f. inn. Med., Wiesbaden, 1910, No. 27, p. 364.

5. Van den Velden, R.: Verhandl. d. deutsch. Kong. f. inn. Med., Wiesbaden, 1910, No. 27.

6. Arnsperger: The Effect of Morphin on the Motor Function of the Gastro-Intestinal Canal of Man, Verhandl. d. deutsch. Kong. f. inn. Med., Wiesbaden, 1910, No. 27.

7. Stierlin and Schapiro: Die Wirkung von Morphium, Opium, Pantopon auf die Bewegungen des Verdauungstrakus beim Menschen und beim Tierschen, München. med. Wchnschr., 1912, No. 50, p. 2714.

8. Meyer-Betz and Gebhardt, T.: Röntgenuntersuchungen über den Einfluss der Abfurmittel auf die Darmbewegungen des gesunden Menschen, München. med. Wchnschr., 1912, No. 33, p. 1794; ibid., 1912, No. 34, p. 1861.

9. Katsch: Physiologisch-pharmacologisches über Darmbewegungen und Darmform-Röntgenkongress, Berlin, 1913.

many cases would vary to a certain extent in two or even more control examinations, and also if more than one drug series were studied, and it is only by dealing with a large number of cases and selecting points of resemblance or widely different effects for tabulation that dependable data of any value can be obtained.

RESULTS OF STUDY

An abstract of the results of study in each case follows:

CASE 1. — *Clinical Condition of Patient.* — Aortic regurgitation.

Medication.—Digitalis and gentian, withdrawn during days of examination.

Condition of Gastro-Intestinal Tract by Control Examination.—Normal except slight colon stasis.

Method of Administration of Morphin.—Hypodermic injections, one-quarter grain with first meal and one-quarter grain seven hours later.

Effect on Stomach.—Apparently none.

Effect on Small Intestine.—A slight but definite delay in motility as indicated by the relative position of the column in the lower ileum.

Effect on the Large Bowel.—(*a*) At the end of eight hours a definite but moderate relative slowing of the opaque column, and probably more than could be accounted for by the lessened motility in the small bowel. (*b*) At the end of twenty-one hours and later, there was no difference from the control.

CASE 2.—*Clinical Condition of Patient.*—Gastric neurosis.

Medication.—None.

Condition of Gastro-Intestinal Tract by Control Examination.—Stomach negative; very slight delay in the terminal ileum due to incompetency; extreme colon stasis.

Method of Administration of Morphin.—Single dose hypodermic injection, one-quarter grain with first meal (six hours before examination).

Effect on Stomach.—Motility slightly increased throughout the time of examination; peristalsis slightly but definitely more vigorous; emptying time definitely shortened.

Effect on the Small Intestine.—At first a slight relative delay, indicated by the position of the column in the lower ileum. Later as the second meal reached the intestine, there was a very decided delay in the jejunum.

Effect on the Large Bowel.—At the end of ten hours there was practically no difference from the control. At the end of forty-five hours, stasis was slightly accentuated.

CASE 3.—*Clinical Condition of Patient.*—Pyorrhea alveolaris and facial neuralgia.

Medication.—None.

Condition of Gastro-Intestinal Tract by Control Examination.—Stomach negative; slight ileal stasis; moderate colonic stasis.

Method of Administration of Morphin.—Continued administration twenty-four hours, hypodermic injections, one-quarter grain, with first meal; one-quarter grain ten and one-half hours later, and one-quarter grain at the end of twenty-four hours.

Effect on Stomach.—Motility, peristalsis and emptying time not appreciably affected.

Effect on Small Intestine.—The first dose caused no delay but on the other hand the column kept ahead of the control; the second dose caused a slightly lessened motility in the upper small bowel which became less marked as the effect wore off.

Effect on the Large Bowel.—No delay from the first dose, the column keeping ahead of the control; the repeated doses caused a decided delay over the control.

CASE 4.—*Clinical Condition of Patient.*—Infectious polyarthritis and oral sepsis.

Medication.—None.

Condition of Gastro-Intestinal Tract by Control Examination.—Negative except an extreme colonic stasis. Inability to empty the large bowel after the control examination rendered it impossible to use this case further.

CASE 5.—*Clinical Condition of Patient.*—Possible pituitary neoplasm.

Medication.—Cannabis indica, stopped during examination.

Condition of Gastro-Intestinal Tract by Control Examination.—Stomach showed varying motility, at times hypermotility, but without hyperperistalsis. Emptying time was delayed beyond six hours. Otherwise negative.

FIRST SERIES: *Method of Administration of Morphin.*—Single hypodermic injection, one-quarter grain with meal.

Effect on Stomach.—Motility and peristalsis were not studied. No residue in six hours, whereas there was a decided one in the control examination.

Effect on Small Intestine.—None, unless a slight increase in motility.

Effect on Large Bowel.—Very slight relative delay in the head of the column.

SECOND SERIES (the following day, after enema): *Method of Administration of Morphin.*—Hypodermic injections, one-quarter grain one and one-half hours before meal and one-quarter grain two and one-half hours after meal.

Effect on Stomach.—The same hypermotility as during the control, but peristalsis was markedly increased. Emptying time prolonged considerably beyond control. The hypermotility caused a decided overcrowding of the duodenum.

Effect on Small Intestine.—A decided delay in the duodenum, with a large cap shadow which remained large after the stomach was about empty. There was also delayed emptying of the third portion, and a slight stasis throughout the small bowel.

Effect on Large Bowel.—Very slight relative delay over the control, more marked early when the drug was active.

CASE 6.—*Clinical Condition of Patient.*—Chronic pulmonary abscess.

Medication.—None.

Condition of Gastro-Intestinal Tract by Control Examination.—Negative except slight colonic stasis.

Method of Administration of Morphin.—Repeated doses by mouth, one-quarter grain one and three-quarters hours before meal, one-sixth grain the same time after meal, and one-sixth grain eight hours after meal for colonic effect.

Effect on Stomach.—Motility: A decided tendency to pyloric spasm, especially early. Peristalsis: Marked hyperperistalsis, especially early and far more vigorous than during control. One decided antiperistaltic wave. Emptying time: Delayed about two hours, probably because of spasm.

Effect on Small Intestine.—Slight stasis in the upper portion and a decided relative ileal stasis.

Effect on Large Bowel.—A decided relative delay in the head of the column while the drug was active, but little if any delay later.

CASE 7.—*Clinical Condition of Patient.*—Heart case.

Medication.—Digitalis, discontinued during examination.

Condition of Gastro-Intestinal Tract by Control Examination.—Stomach showed delay in emptying beyond eight hours. Slight colonic stasis.

Method of Administration of Morphin.—Closely repeated doses by mouth, one-quarter grain one and three-quarter hours before meal, one-sixth grain one and one-quarter hours after, and one-sixth grain three hours after.

Effect on Stomach.—Motility about the same as control; peristalsis more vigorous in the pyloric portion and continued so, with deep segmenting waves; emptying time decidedly prolonged by the repeated doses, although motility was ample after the first dose, indicating spasm.

Effect on Small Intestine.—In upper portion, a delay only after the third dose. A slight delay as noted by the column in the lower ileum, for which the stomach was partly responsible.

Effect on Large Bowel.—Very little delay, as the drug was given early.

CASE 8.—This case deserves special mention because of its unusual interest from the clinical standpoint and because many of the unusual phenomena noted were similar to those observed in connection with the morphin case previously reported.[1]

Clinical Notes on Case.—Drug habitué, addicted to the use of heroin especially, and also cocain. Had been off heroin for two and one-half months. Was admitted because of the drug habit and his general condition resulting therefrom. No medication.

Condition of Gastro-Intestinal Tract by Control Examination.—No examination was made.

Method of Administration of Drug.—Six doses of heroin hydrochlorid, one-sixth grain, given the day before the examination by mouth every third hour. Following this a diarrhea started at night.

Notes Made at the Examination.—The first fluoroscopic examination was made directly after the administration of the opaque meal, without other food. The stomach showed a complete hour-glass constriction at about its middle portion, and the appearance was similar to that observed in the previously reported morphin case.[1] This relaxed gradually but not completely, and as it relaxed, there was a tendency to hypermotility without any visible peristalsis (as observed also in the morphin case), and the entire duodenum became overfilled without the passage of any opaque material further. The noteworthy features were the early hour-glass constriction followed by gradual relaxation, hypermotility without peristalsis, and the distention and apparent atony of the duodenum.

Two hours later, the upper portion of the stomach still contained considerable opaque food, and it again showed a complete hour-glass constriction, with a small amount of contents in the region of the pylorus. The upper small intestine was well filled and showed lack of motility.

Four hours after the meal there was still a residue above the hour-glass constriction, and a small amount in the pyloric region. The upper small intestine showed even greater paresis. At the end of six and one-half hours the appearance was much the same, and at the end of eight hours there still remained some residue above the constriction, and the opaque column was progressing very slowly through the small intestine. The residue from the start of the examination had been almost entirely above the hour-glass constriction, and the lower half of the stomach seemed to empty readily and rapidly. There was no evidence of pyloric spasm as noted in so many of our morphin cases.

A sixth fluoroscopic examination, made twenty-four hours after the meal, showed almost all of the opaque material distributed throughout the coils of small intestine. The colon was distended with gas but contained very little bismuth.

Résumé: *Effect on Stomach.*—Hour-glass constriction at middle, relaxing somewhat when the stomach was filled, and contracting again as it emptied. Motility: Marked hypermotility in the lower half, with retention in the upper half. Peristalsis not noticeable. Emptying time delayed over eight hours, but almost entirely in the upper pole.

Effect on the Small Intestine.—Primarily, overfilling of the duodenum and then a prolonged paresis of the entire small bowel, continued over twenty-four hours.

Effect on the Large Bowel.—This was not studied, as very little opaque material had reached it in twenty-four hours, and the patient's condition did not warrant further study.

CASE 9.—*Clinical Condition of Patient.*—Early acromegaly.

Medication.—Liquid petrolatum, 30 c.c., twice daily, and mixture of sodium bromid, tincture of hyoscyamus and camphor three times a day. By mistake this was not discontinued during the control examination, and was therefore continued during the morphin studies.

Condition of Gastro-Intestinal Tract by Control Examination.—Negative.

Method of Administration of Morphin.—Closely repeated doses by mouth as in Case 7: One-quarter grain one and one-half hours before meal, one-sixth grain one and one-half hours after, and one-sixth grain three hours after meal.

Effect on Stomach.—Motility: The amount which passed through the pylorus was not commensurate with the peristalsis. There was an intermittent pyloric spasm which was very marked at times, while at other times the pylorus seemed to relax to a normal degree. Peristalsis: Intermittent hyperperistalsis, which continued throughout the examination. Emptying time: No relative difference at first, but the repeated doses caused from two to three hours' delay.

Effect on Small Intestine.—Only a slight though definite effect at first, but a considerable relative delay through a large area after the repeated doses.

Effect on Large Bowel.—Delay at first evidently due to small intestine stasis. No delay at twenty-four hours. (Patient taking oil.)

CASE 10.—*Clinical Condition of Patient.*—Idiopathic epilepsy.

Medication.—None.

Condition of Gastro-Intestinal Tract by Control Examination.—Stomach negative; hypermotility, small intestine; slight colonic stasis.

Method of Administration of Morphin.—Closely repeated doses by mouth with concentration of effect earlier than preceding case, one-quarter grain four hours before meal, one-sixth grain one-half hour before, and one-sixth grain two hours after meal.

Effect on Stomach.—Motility: Decided hypermotility early, but this rapidly subsided until there was evidence of pyloric spasm later. Peristalsis apparently not affected until late, when it seemed to increase as pyloric spasm became manifest. Emptying time prolonged several hours as the later effect of pyloric spasm.

Effect on Small Intestine.—Motility still rather rapid, but lessened as compared to control. The duodenum was sluggish in propulsion.

Effect on Large Bowel.—Increase in colonic stasis, as indicated by position of head of column.

CASE 11.—*Clinical Condition of Patient.*—Chronic bronchitis; infectious polyarthritis.

Medication.—None.

Condition of Gastro-Intestinal Tract by Control Examination.—Decided colonic stasis.

Method of Administration of Morphin.—Hypodermic injections given entirely before meal and carried to the physiologic action of contraction of the pupil, one-sixth grain ten hours before, one-sixth grain seven hours, one-sixth grain four hours, and one-sixth grain one hour before the meal. The only case in which any contraction of the pupil was noted.

Effect on Stomach.—Motility: Tendency toward intermittent pyloric spasm, which was rather overcome by increased peristalsis and gradually subsided as the effect of the drug wore off. Peristalsis irregularly violent at first but gradually subsided as the effect wore off. One antiperistaltic wave seen early. Emptying time not delayed, keeping pace fairly well with the control throughout.

Effect on Small Intestine.—No delay whatever at any time.

Effect on Large Bowel.—No delay whatever.

CASE 12 (female).—*Clinical Condition of Patient.*—Ménière's disease.

Medication.—Sodium bromid and nux vomica, discontinued during examination.

Condition of Gastro-Intestinal Tract by Control Examination.—Nothing abnormal in connection with stomach, but patient vomited early in each series. Colon examination not made.

Method of Administration of Morphin.—Single dose hypodermic injection, one-quarter grain, half an hour before meal.

Effect on Stomach.—Motility: Decided early and persistent intermittent pyloric spasm. Peristalsis greatly increased, deeper but not more frequent waves. Frequent antiperistalsis. Emptying time increased about two hours, owing to continued pyloric spasm.

Effect on Small Intestine.—Considerable relative delay throughout the examination of eight hours.

Effect on Large Bowel.—Not studied.

CASE 13.—*Clinical Condition of Patient.*—Rheumatoid arthritis.

Medication.—None.

Condition of Gastro-Intestinal Tract by Control Examination.—Probably some perigastric adhesions not affecting function.

Method of Administration of Morphin.—Single dose hypodermic injection, one-quarter grain, forty-five minutes before meal.

Effect on Stomach.—Motility: No effect at first, but pyloric spasm became evident soon, but gradually subsided as effect of drug wore off. Peristalsis more vigorous than during control period, but not excessive. Later it became very inactive. Emptying time delayed over four hours, owing to early spasm and later inactivity.

Effect on Small Intestine.—Decided stasis in upper small bowel, including duodenum, but without distention.

Effect on Large Bowel.—None.

COMMENT

It should be borne in mind that the Roentgen examination is a method of studying only a single phase of drug effects on the gastro-intestinal tract. It shows better than can be demonstrated by any other method how the various portions of the digestive canal act in the propulsion of opaque food contents when under drug influence as compared to their action during normal or control periods.

We realize that even as a preliminary report our work is lacking in several important respects, and first of all in the small number of cases we have been able to study. Secondly, after conclusive proof of certain definite effects due to morphin, we had expected to compare these results with those due to some of the other preparations of opium, but we found the effects of the former so unlike in different individuals that it was difficult to form a basis for comparisons. Our experience has shown us that the only accurate way of making relative estimates would be to carry out a series of investigations with morphin and other preparations on the same cases. Thirdly, we had hoped to add to our list of eleven morphin cases at least one showing the unusual idiosyncrasies to moderate doses of the drug manifest by obstinate vomiting, but none were available for the purpose. In no one of the eleven of this series was repeated even the unusual phenomena observed in the case previously reported,[1] although the heroin case (Case 8) showed very similar effects.

What little we have done has shown that there is an enormous amount of valuable work yet to be accomplished in connection with the study of drug action by the Roentgen examination. There are innumerable therapeutic agents yet to be studied in this way, and the comparatively little work that has been done along this line needs further confirmation. English literature is noticeably lacking in this field of Roentgen investigation.

The most surprising result of our observations has been the lack of any degree of uniformity in the effects produced in different individuals. This was as noticeable in connection with the stomach as it was in the intestinal tract. While we have been able to duplicate the phenomena observed by other writers, we have found them to be far from uniform. Van den Velden[5] states that small doses of morphin (0.5 cg.) increased peristalsis in the pyloric region. Our smallest dose was never less than three times this. He found that moderate doses (1 cg.) caused in addition a marked constriction in the region of the pyloric sphincter which we never observed, and could cause a complete hour-glass constriction, dividing the fundus from the pyloric region. This was observed in none of the eleven cases in our series, many of which had much larger doses, but was seen in the case previously reported,[1] and in our heroin case. Large doses (2 cg.) increased the effects and caused opening of the cardia and vomiting, which was not observed by us.

In two of the eleven cases the morphin in a one-quarter grain dose seemed to exert no noticeable effect whatever on the stomach or its motility. The most striking effect was an increase in the emptying time, usually from two to four hours, and observed in seven of the cases. In one (Case 11) it was not delayed although pyloric spasm was evident, and in another (Case 2) it was shortened. There was decided evidence of pyloric spasm in seven cases, while motility was increased in two instances, in one of which, however, pyloric spasm was manifest late. Peristalsis was increased in intensity, the waves being deeper and occasionally more rapid in all nine cases in which there was shown any appreciable effect from the morphin. This proved, therefore, to be the most uniform finding. Antiperistalsis was noted in three cases. Peristalsis was usually increased only in the pyloric portion, but occasionally a hyperperistaltic wave was observed along the entire organ. The increase was usually seen to be associated with pyloric spasm. In some individuals small doses produced no appreciable effect, while in some the phenomena were as marked as were those observed in other cases following very much larger doses.

Whether or not the increase in emptying time was due to hypersecretion which precipitated pyloric spasm, as has been mentioned by some writers, or whether it was even associated with a hypersecretion any greater than might be expected in prolonged retention, we are unable to state.

Arnsperger,[6] van den Velden[5] and others call attention to the fact that because food remains longer than usual or normal in a stomach that is under the influence of morphin, the use of opium is undesirable in gastric conditions in which the emptying time is increased, as perigastritis, adhesions, ulcers, carcinoma or reflex pyloric spasm from outside causes. No doubt this might be the case occasionally and the continued use would be so almost invariably, but we cannot see how any direct harm could result in these conditions in most instances from the occasional use of the drug when needed. Moreover, how much additional effect morphin would have in prolonging the emptying time in such conditions, and especially those in which pyloric spasm is a cause of delay, as ulcer, is a field for further study. On the other hand, because morphin delays the emptying time we would not consider its routine use indicated in conditions in which hypermotility is present, as achylia gastrica, and especially because of its effect on the small bowel.

Practically all authors agree that morphin lessens motility in the small intestine. Unlike the stomach, delayed motility in the small bowel seems to result from a lack of propulsion instead of spasm. It may be manifest only as an apparent relative delay of the column in the lower ileum, which we have regarded as an index of a slightly lessened motility higher up along the tract. In many of our cases, and especially in the one previously reported[1] and in the heroin case of this series, the lessening of the motility was so marked as to be noticeable throughout a large part of the small bowel. This was most noticeable in the jejunum, but sometimes in the duodenum as well, or in other words, in the portions where the most rapid movement is normal. Stierlin and Schapiro[7] raised the question of spasm of the ileocecal valve being a cause of delay there, but so far as we could note there was no unusual crowding of contents in the terminal ileum.

Arnsperger[6] states that the small intestine showed slowing in all cases examined. We found this to be

fairly constant, having been observed in ten out of the eleven cases of the morphin series. In the one exception, the case which received the largest dosage, and the only one in which contraction of the pupil was noted, no effect whatever was shown by the small bowel. In one of the ten positive cases, which was examined twice, a single dose produced no appreciable effect, but at the second examination when the dose was doubled, there was a noticeable delay. In another of the ten cases a hypermotility was lessened. In nine of the ten cases showing delay, there was evidence of this in the upper portion of the bowel.

Experience has shown that our method was not the ideal one for studying the effect on the large bowel, although our results were very much the same as those of others. As a rule this part of the tract was studied at the end of the examination, after the active influence of the drug had subsided partially or entirely. A more accurate method would be to administer the drug at about the time the cecum was filled and the terminal ileum nearly empty — from six to eight hours after the meal in the average case. This was the procedure followed by Arnsperger.[6] His results were very variable, however, with different doses and with different individuals given the same doses. Stierlin and Schapiro[7] found that morphin had no effect of any consequence on the large bowel.

In all of our cases the large bowel was studied in connection with the tract higher up. Our conclusions were based mainly on the relative position of the head of the opaque column as compared to the control. The colon was studied in ten cases, and a noticeable delay in the head of the column was observed in six, and no apparent effect in three, two of which received small early doses and the other case which received the largest dose of any. In one of the ten, delay was doubtful.

So far as we were able to judge, it made little difference whether the morphin was administered by mouth or subcutaneously. The only accurate way to determine the relative effect of varying dosage would be to examine the same individuals repeatedly with increasing doses, as small or single doses in one individual may produce the same or a more marked effect than large or repeated doses in others. Of the two sexes, females seemed to be more susceptible.

CONCLUSIONS

The Roentgen examination is a valuable method of studying certain phases of drug effects on the gastrointestinal tract, especially motility, and the knowledge it furnishes can be gained better by this method than by any other.

Our observations were made in a series of eleven cases given morphin and one heroin habitué. While we have been able to duplicate the phenomena observed by others, with one exception, there was a decided lack of uniformity in the effects produced in different individuals, in connection with both stomach and bowel.

There is no distinct uniformity in connection with dosage. Small doses in some may produce more marked effects than much larger doses in others. Females appear to be more susceptible.

In the stomach a rather high spasmodic hour-glass contraction is observed rarely, but we have not seen this near the pylorus as described by others. In some instances the stomach may show no appreciable change from normal. In most cases there is more or less pyloric spasm, increased peristalsis and a decided prolongation of the emptying time.

In the small intestine, morphin causes decreased motility almost uniformly, apparently as a result of a lack of propulsion and not of spasm. When marked, it is most noticeable in the upper small bowel.

The effect on the large bowel is very variable and probably of little consequence.

Oral administration produces practically the same effect as subcutaneous injections.

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THE ENDOWMENT OF CHILDHOOD FROM THE OBSTETRIC STANDPOINT *

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The present era in the practice of medicine, like the preceding periods, is one of transition, and the goal, the conservation of health and the prolongation of life, is hampered by ignorance, mysticism, superstition and exploitation. The beacons of scientific investigation, clinical observation and experience, however, are steadily revealing the mysteries of Nature, and are thereby enriching our knowledge in the alleviation, prevention and cure of disease. Down through the ages each period has contributed more or less to this progress, and we are not unmindful of the rich heritage we enjoy in the possession of the accumulated knowledge and treasures of our predecessors which form the granite ground-work of the art and science of medicine.

Each era has been distinguished for some epoch-making contribution. Ours is particularly noted for the development of an aseptic technic which has revolutionized the practice of surgery and obstetrics. We were present at the christening, if not the birth, of that science, bacteriology, which has placed preventive medicine and sanitation on a rational and enduring basis. A half century ago the practice of surgery was mostly of an emergency character, caring for fractures, dislocations, gunshot wounds, etc., while today three fourths of the operations are elective and cover a wide field of application. "No cavity is now too deep and no organ too important or vital to deter from direct interrogation. By vision and tact, the gravity, density and magnitude of any, of every part, may be revealed to the sensorium and adjudicated by the unerring edict of positive knowledge."[1]

The more important advancements in obstetrics as the result of these recent developments are the awakening interest in prenatal care and the prevention of infant mortality, the practical abandonment of craniotomy on the living child, and the broadened indications for cesarean section.

In my previous address[2] on "The Endowment of Motherhood," I made a plea for better obstetrics in general practice, and expressed the belief that the solution lies in more intensive training of the students in practical obstetrics and educating the public to the necessity of efficient care of woman in the most important epoch in her life.

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* President's address, read at the meeting of the Washington Obstetrical and Gynecological Society, Oct. 8, 1915.

1. Miller, DeLaskie: Tr. Ninth Internat. Med. Cong., ii, 302.
2. Moran, John F.: The Endowment of Motherhood, THE JOURNAL A. M. A., Jan. 9, 1915, p. 122.

Of course, accrued benefit to the unborn child was implied in this advanced obstetric teaching and practice, but I wish now to direct attention more specifically to what has already been accomplished regarding its welfare and the prospective possibilities of the future.

The importance of the subject does not arise from the frequency with which its problems are presented but from the grave emergencies created by them — emergencies which demand early recognition and prompt decision by the physician in that they involve the lives of the mother and child, as well as points of professional honor and conscience.

The longer I practice obstetrics, the more deeply I am impressed with the difficulty which often presents itself of deciding when to interfere and what particular method of intervention to elect. In no other field of medicine is a well-balanced judgment and skill more requisite for success; and not infrequently, even then, the result is fortuitous.

"When it is realized that practically 38 per cent. of the deaths under 1 year of age are due to causes mainly dependent upon the health and condition of the mother during pregnancy and confinement; that within the registration area of the United States of 154,373

TABLE 1.—CAUSES OF DEATH FOLLOWING CONFINEMENT

Cause	No.	Per Cent.
Prematurity	250	40
Inanition	99	15.8
Accidents of labor	34	5.4
Atelectasis	30	4.8
Asphyxia, pallida	21	3.3
Asphyxia, accidental	11	1.7
Patulous foramen ovale	11	1.7
Congenital syphilis	22	3.5
Hemorrhage of the new-born	26	4.1
Enteritis	40	6.4
Pneumonia	19	3
Toxemia	12	1.9
Convulsions	12	1.9
Malformations	9	1.3
Miscellaneous	27	4.3
	623	

infants under 1 year of age, who died in the year of 1910, 14,964, or nearly 10 per cent., lived less than one day; that 36,351, or practically 23.5 per cent., lived less than one week, it will be seen that the infant mortality problem cannot be solved adequately by any measures which leave out of their scope some attention to the care of the expectant mothers." Since the foregoing sentence was written, the mortality statistics for 1911, issued by the Bureau of the Census, show a more distressing situation than was revealed by the figures of 1910. With an increased death registration area (now covering 63 per cent. of the total population), there was a decrease in deaths of children under 1 year to 149,322 as against 154,373 in 1910. But those who lived less than one day increased not only relatively but also absolutely, that is, from 14,946 in 1910 to 40,883, or 27.4 per cent., in 1911. These figures show that the efforts made to save babies through pure milk and more intelligent care have produced results, while lack of organized effort to reach prenatal conditions for a very considerable period or over any extended area has further emphasized its need.[3]

These figures of the death toll of early infancy are appalling, and show that besides the unavoidable mortality incident to childbirth, many infants are born hopelessly handicapped for life's struggle, while many more perish through ignorance and neglect.

The illuminating papers of Williams,[4] and Holt and Babbitt,[5] on institutional infant mortality incident to childbirth and the two weeks following, show on careful analysis of 10,000 consecutive cases by each reporter how a very large percentage of the mortality could have been averted by intelligent supervision of pregnancy and competent care during labor.

TABLE 2.—STILLBIRTHS (INCLUDING ABORTIONS)

Cause	No.	Per Cent.
Unknown	342	47.4
Congenital syphilis	84	11.7
Accidents of labor (difficult and prolonged, 50; prolapsed cord, 64; cord around neck, 5; knotted cord, 4)	123	17.1
Toxemia and eclampsia	34	4.7
Asphyxia	35	4.7
Accidents (violence)	28	3.9
Monsters	6	.8
Placenta praevia	30	4.1
Accidental hemorrhage	23	3.2
Miscellaneous	11	1.5

In this connection I wish to invite attention to a summary of a review of 10,533 confinements which occurred in the obstetric service of Columbia Hospital from July 1, 1876, to June 30, 1915. They were divided as follows: stillbirths (including abortions), 716; living births, 9,817.

The hospital is open to the profession. All classes are received. More than 60 per cent. are admitted in labor, and over 70 per cent. of the confined are colored. The free patients are discharged on the eighteenth day, though in case of illness the time is extended to meet the requirements.

It will be observed from the tables that the "unknown" forms the largest contingent of fetal

TABLE 3.—GENERAL MORTALITY

Cause	No.	Per Cent.
Unknown	342	24
Prematurity	250	18.5
Accidents of labor	157	11.7
Syphilis	106	7.9
Inanition	99	7.9
Asphyxia, pallida	56	4.1
Asphyxia, accidental	11	.8
Patulous foramen ovale	11	.8
Toxemia and eclampsia	46	3.4
Enteritis	40	2.9
Placenta praevia	30	2
Accident (violent)	28	2
Hemorrhage of the new-born	26	1.9
Atelectasis	30	2
Accidental hemorrhage	23	1.7
Pneumonia	19	1.4
Malformation and monsters	15	1
Convulsions	12	0.8
Miscellaneous	38	2.8

deaths — nearly 50 per cent. of the stillbirths and 24 per cent. of the total infant mortality. This is because diagnosis was usually based on clinical data and often incomplete history, and frequently because a satisfactory explanation was wanting. Routine Wassermann, other laboratory tests and necropsies would surely have proved many of this group to have been due to syphilis. Bearing on this point, the following data furnished me by Mr. Peter, the pharmacist, is of much

3. Baby Saving Campaigns, p. 381, Infant Mortality Series, No. 1, Publication 3, Children's Bureau, U. S. Dept. of Labor.

4. Williams, J. Whitridge: The Limitations and Possibilities of Prenatal Care, THE JOURNAL A. M. A., Jan. 9, 1915, p. 95.

5. Holt, L. Emmett, and Babbitt, Ellen C.: Institutional Mortality of the New-Born, THE JOURNAL A. M. A., Jan. 23, 1915, p. 287.

significance. Of 171 Wassermanns done in the past four years in the obstetric department, 113 were positive, and out of this number thirty-five, or 30+ per cent., were stillbirths. Out of the fifty-eight negative reactions there was only one stillbirth. It would probably be a safe estimate to say that at least 40 per cent. of the unknown stillbirths was caused by syphilis.

Prematurity, syphilis, inanition, atelectasis and toxemia constitute nearly 70 per cent. of the total mortality, and are independent of labor. These factors influence pregnancy disastrously, and yet are largely preventable and amenable to well-directed treatment.

The causes intimately connected with intrapartum mortality are malpresentation, forceps operations (asphyxia and intercranial hemorrhage), placenta praevia, ablatio placentae, rupture of the uterus, eclampsia, tetanic uterine contractions, etc., and were responsible for 18 per cent. of the fetal deaths.

It is difficult to estimate the probable percentage of this group that might have been saved, because many operators officiated and naturally the judgment and skill varied accordingly. I know, however, from personal experience and observation, extending over a number of years, as intern and member of the visiting staff, that I and others were responsible for some of the mortality because of errors of judgment and execution.

Pneumonia and enteritis were the most frequent mortality factors after confinement, and with the miscellaneous and accident groups made up 9 per cent. of the total, while hemorrhages of the new-born and malformations and monsters yielded 3 per cent.

This summary emphasizes the indubitable fact that there is a needless sacrifice of infants because of the neglect of prenatal care, and that early recognition of abnormal conditions and timely intervention would have averted many of the intrapartum disasters.

The public should be taught that the risks attending parturition can be, for the most part, avoided by intelligent oversight of the parturient; by preparedness for rendering aid when needed no less than by masterly inactivity when normal.

Much good is being accomplished by the various organizations engaged in the welfare of motherhood and childhood, by stimulating general interest in the cause and securing lay and professional cooperation; but if this much to be desired beneficence is to become nation-wide, the checking and follow up system can be satisfactorily done only under state subsidy and control.

For some inscrutable reason, the life of the child has been held to be of unequal value compared with that of the mother, and in complicated childbirth, when both lives are in jeopardy, the child is to be sacrificed. This is contrary to natural law, according to which all lives are equal; and furthermore, science has shown that this dictum is untenable in that there is no conflict between the life of the mother and the life of the child, and the direct sacrifice of either in the interest of the other can be defended, if at all, only on the ground of expediency and not on the claim of justifiability.

Expediency is a subterfuge used to subordinate right and justice to might and convenience, whether it be in the stifling of a human life in its inception by that heinous crime of convenience, criminal abortion, or the deliberate taking of a life in the fulness of its development and when ready for external existence by a destructive operation.

The passing of craniotomy on the living child is one of the greatest triumphs of modern obstetrics — a veritable turning of defeat into victory. Practiced almost from the dawn of civilization, down through the centuries, this mutilating operation is happily being supplanted by humane methods of intervention that have for their purpose the saving of both lives.

In this connection, I quote from the recent interesting paper of Dr. Wall.[6]

> It cannot be charged against us, as it was in the earlier days of medicine, that the interests of the child are entirely subservient to those of the mother. The abandonment of craniotomy on the living child was an acknowledgment of infantile rights, which, thanks to modern advancement in medical science, have attained a station hitherto unknown, so that the mortality of the child is mentioned in the same breath with that of the mother in almost all obstetrical conditions and procedures.
>
> I am of opinion that there is still room for improvement in judging the rights of the unborn child, and there are certainly enormous opportunities for advancement in the consideration and attention bestowed on the little individual after birth.

It is to the honor of this society, dedicated to the cause of motherhood and childhood, that its first anniversary (1883) was made memorable in the defense of the rights of the unborn child. The president, Dr. Busey, in a trenchant and forcible address, challenged craniotomy on the living child as being unethical and unscientific, and, in the light of medical progress, should be abandoned in favor of cesarean section and other conservative measures.

Until less than twenty-five years ago, cesarean section was rarely performed save for contracted pelvis, obstruction of the birth canal by tumors and in the case of sudden death of the mother, while today it embraces in its broadened scope not only deformities of the pelvis but also some cases of placenta praevia, eclampsia, disproportion between the size of the child and the pelvis, heart disease, ventrifixation, stenosis of the cervix and vagina, edema of the vulva and accidental hemorrhage; and a member of this society, Dr. Bowen, has recently advocated it for certain breech cases, particularly, in aged primiparas after a test labor, even though the pelvic measurements are normal.

I am in accord with this recommendation, for the usual methods of practice in this class of cases are attended with an infant mortality of from 10 to 20 per cent. In discussing the case reported by Dr. Bowen, I said:

> Under the conditions mentioned with the patient showing signs of fatigue, evidenced by increased pulse rate, uterine inertia, etc., cesarean section was not only justifiable but a rational method of procedure, even though the pelvic measurements be normal. If the bag of waters were intact and condition of mother and child favorable, some would advocate further trial aided with sedatives. Instead of putting forth "the desire for a live child," I would make it stronger by substituting "the inherent moral and legal right of the child to be born alive." I had two somewhat similar cases recently in consultation, in one of which I resorted to slow extraction, against the better judgment of the attending physician, who suggested the advisability of cesarean section, lost the baby and got severe perineal laceration and colon infection. In the other case, classical cesarean section was done with happy results to mother and child.

6. Wall: The Status of the Child in Obstetric Practice, read before the Washington Obstetrical and Gynecological Society.

In the complications that confront the obstetrician, there is none that is fraught with more danger or attended with greater anxiety than placenta praevia, save perhaps eclampsia. Its sudden manifestation, often alarming hemorrhage and consequent anemia, shock and possible infection present a formidable array of difficulties that even in the hands of the most skilled has been attended with a high maternal mortality. It is true that in recent years, with more definite method of treatment and advances of antisepsis and sepsis, the maternal death rate has been greatly lessened, but the extraordinarily high proportion of infants lost remains unchanged.

If we analyze the statistics, we cannot fail to recognize that it is the lateral and marginal varieties that have contributed largely to this improved showing by directly sacrificing the life of the child by using it as a plug to control the hemorrhage. In central implantation, modern methods have not materially affected the death rate. It was quite natural, then, that other measures would be evolved with the hope of reducing the frightful infant mortality, while still not increasing, if not improving the chances of the mother. Hence for more than two decades, from time to time, the justifiability of cesarean section in certain cases of placenta praevia, in the interest of the child as well as the mother, has claimed the attention of the profession. Some have recommended it on theoretical grounds, with the conclusion that it is not only justifiable, but also indicated in central implantation of the placenta. On the other hand, there are those who are equally positive in their belief that cesarean section has no legitimate field in placenta praevia, contending that the mother's life is of paramount importance; and further, that many of the infants will of necessity be born prematurely and likely to succumb at birth. The physician has no moral right to decide between the value of two lives, nor is he in conscience capable of determining whether the child will survive or not. Both are his patients, entitled to his best skill, and he is in honor bound not to deliberately sacrifice the life of one to save the other.

The induction of premature labor, though offering little danger to the mother, is opposed on the ground of fetal mortality. Besides, it is not an easy matter to determine the time for intervention, and the widest experience and most painstaking study and keenest mechanical sense are requisite for successful issue of this operation.

Expediency rather than fitness is often the determining factor in choosing the method of intervention in obstetric practice. The physician without surgical bent or training relies on such measures which, while usually safeguarding the mother's welfare, are often inimical to the interests of the child. How often do we see cases of delivery by forceps or version in which the child is sacrificed at birth or dies within a few days afterward of cranial hemorrhage? It is with the borderline cases that we have so much difficulty, and they require the most exacting care in deciding how best to act in the interests of both lives. The great mistake that many make is to apply forceps in cephalic presentations regardless of position and whether the head is engaged or not. The cardinal rule is that forceps should never be applied to a head that has failed to enter the brim of the pelvis, for in a very large percentage of cases disaster will be almost sure to follow.

I do not wish to be understood as in any way underestimating the value of forceps, version and the induction of premature labor, as they have their field of usefulness; nor am I unmindful of the fact that in the majority of cases the children would deliver themselves unaided; but what I do advocate is that more attention be given to the patient during pregnancy and that at the appropriate time a careful and thorough examination be made so as to be prepared to intervene at the proper time in the interest of both mother and child.

During the past year considerable attention has been given to *Dämmerschlaf* or "twilight sleep" in the medical and lay press. The Freiburg method was tried out in this country nearly a decade ago and practically discarded. Through the restatement of the method by one of the proponents, reiterating its claims for producing amnesia in labor, and the prompt exploitation of the address in a lay magazine article, the interest in the treatment has been reawakened, and the method is again being given a trial in several hospitals and by others. It matters little whether the lay propaganda is due to the alluring euphony of "twilight" or to commercial cupidity, when compared with the duty of the profession to settle definitely whether the method possesses the value claimed for it. This the searchlight of experience will determine, and the profession will before long be able to decide if it is to fill a much desired want in obstetric practice or share the fate of spinal analgesia.

With a view of learning of the status of *Dämmerschlaf* in Germany and elsewhere in Europe, I wrote to Professor von Heff, director of the Frauenspital, Basel, Switzerland. He replied as follows:

> I do not employ *Dämmerschlaf* (twilight sleep) because it requires constant supervision, also because it excites a number of the patients, and in my judgment the infants are likewise endangered. Years ago I made experiments which did not satisfy me. The results are given by von Dietschy, whose article I send you. In a large maternity like this where the lying-in women cannot be isolated, the treatment is, according to Krönig, contraindicated. So far as I can see, *Dämmerschlaf* is little used in Switzerland. If used at all it is by physicians who have private clinics, hence "painless labor" is to them a valuable advertisement. In Germany also one does not enthuse greatly, and I believe the majority of my colleagues decline this method, for example Fehling. In isolated cases, quite naturally, it is of service.

This criticism, from the knowledge I have gathered from the current literature, is very fair. That scopolamin will produce amnesia is conceded, but its utility and freedom from danger are not generally accepted. Reports of its indications and limitations are accumulating, and the almost universal discordant note is that it is not without danger to the child. Dr. Mundell has kindly placed at my disposal the replies of eight of the leading obstetricians in this country to whom he wrote asking advice regarding the use of the Freiburg treatment. Those who favor its use restrict it to the first stage, and all but one emphasized its danger to the infant.

There has been much undeserved criticism of those investigators who insist that the treatment should be given only by an expert. The fact that it should be administered only by one who has had experience and that it is not feasible in general practice will, if for no other reason, operate against its general adoption.

The field of obstetric practice has rarely been invaded by the quack, the work being too arduous and unremunerative; but the physicians who for mercenary considerations are imposing on the credulity of their

insistent patients for the Freiburg treatment, by giving them "near" twilight sleep, are courting charlatanry.

Obstetrics appears, as it passes before the mental vision, like a panorama of light and shade. Supposed discoveries in the science and improvements in the art illuminate the scene, till the crucial light of experience casts a shadow of disappointment over the factitious light. We seek the truth. Physicians know too well that the search is surrounded with difficulties, for we advance along the asymptote of the hyperbola; though we have not attained the absolute, we are approaching the object of our quest.[1]

There are still many problems in obstetrics to be solved, including a remedy that will produce amnesia in labor or preferably eutocia, at will—*tuto, cito, jucunde*, safely, quickly, pleasantly. Meanwhile let us continue to mitigate the pangs of labor with the measures which in succoring the mother do not jeopardize the life of her child.

The keynote to decreasing the appalling infant mortality is good obstetrics, and the watchword is efficiency—efficiency in prenatal care—so that at the time of birth, mother and child shall be in the best possible condition, and efficiency in the conduct of labor, whether it be in the rôle of "watchful waiting" or masterly activity, in order that the child shall be assured its inalienable right to be born alive and healthy, and the mother safeguarded to a successful and happy fruition of her noblest mission in life—maternity.

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WHERE CHIROPRACTORS ARE MADE

THOMAS F. DUHIGG, M.D.
DES MOINES, IOWA

As the season for legislation approaches, I feel that the information I have concerning chiropractors should be put at the disposal of those interested in guarding the public health and maintaining respectable educational standards. The chiropractor's machine-made bills will be introduced into the legislature of every state where they have not received recognition.

Iowa schools of chiropractic probably graduate more than the schools of any other three states. Davenport is called the home of this sect; but Iowa does not recognize chiropractors, and they are liable to a fine of $300 if they practice here. Obviously they swarm to other states, in some of which they are permitted by law to practice, and in others they are merely tolerated. It strikes us as peculiar that other states, some with high educational standards, should take large consignments of our "graduate" chiropractors who have graduated from schools which require no preliminary qualifications and which have no libraries or hospitals—graduates of schools without any standing, inspected by no one, regulated by no one and conforming only to their own low estimate, which refers entirely to financial and not at all to scientific standards.

After reading the reports of the inspector of the state of Pennsylvania, I believe the forty-seven other states will exclude the graduates of the Iowa schools of chiropractic the same as Pennsylvania has done. This report is remarkable in that it was made by one outside Iowa and in the interest of the health of the people of a far distant state. It is a testimonial to the care and judgment exercised by the officials of the great commonwealth of Pennsylvania in safeguarding the lives and health of those they are sworn to protect. Likewise it is an indictment of the officials in all those states which have accepted these graduates without first having made a careful inspection and ascertained the extreme wretchedness of the physical equipment of the schools and the mental equipment of their graduates.

The accompanying tabulation gives the reports on the three schools of chiropractic at Davenport, Iowa, made by the inspector of the Pennsylvania Bureau of Medical Education and Licensure.

CHIROPRACTIC COLLEGES OF IOWA

A TABULATION FROM REPORTS OF THE INSPECTOR OF THE PENNSYLVANIA BUREAU OF MEDICAL EDUCATION AND LICENSURE

	Davenport College	Universal College	Palmer School
Buildings	One, an old church.	One fair size	Four (crowded)
Access to hospitals	None	None	None.
Dispensary facilities	Saw no evidence of	Ample*	
Admission requirements.	None	Common school	Common school.
Anatomy, dissecting	Not taught.	Dissect a few dogs	Only dogs dissected.
Histology	No equipment	Didactic only	Very incomplete.
Embryology	Not taught.	Not taught.	Not taught.
Surgical anatomy	Not taught.	Not taught.	Not taught.
Physiology	Didactic only	Lectures only	Lectures only.
Physiologic chemistry.	Not taught.	Lectures only	No equipment.
Chemistry, inorganic and organic.	Not taught.	No practical work done by students	No equipment for teaching.
Pathology	*	*	*
Bacteriology	Not taught.	Not taught.	No equipment.
Pharmacology	Not taught.	Not taught.	Not taught.
Microscopic diagnosis.	Not taught.	Not taught.	Not taught.
Medicine	Not taught.	Not taught.	Not taught.
Pediatrics	Not taught.	*	*
Nervous and mental diseases.	*	*	*
Surgery	Not taught.	Not taught.	Not taught.
Anesthesia	Not taught.	Not taught.	Not taught.
Gynecology	Not taught.	Not taught.	*
Eye, ear, nose and throat diseases.	Not taught.	*	*
Dermatology and genito-urinary diseases.	*	*	*
Class rooms	One	Two	Four.
Clinical amphitheater.	One large room		Two.
Medical library	None	Small	None.
Microscopes	None	Two	Twelve
Having oil immersion.		One	One.
Reflectoscopes	None	Yes	Yes.
Stereopticons	None	Yes	Yes.
Obstetric manikin	Part of one	Yes	Yes.
Maternity work	Not taught.	Not taught.	Lectures only.
Charts	A few	Large supply	Large supply.
Models	None seen.	Yes	Yes.

* This subject is taught only from the chiropractic standpoint, as it is related to certain spinal "lesions."

Regarding the individual colleges the inspector made the following statements:

Davenport College of Chiropractic.—"Their alleged 'chemical laboratory' consisted of a table about 18 inches square, on which were six dusty bottles and three dirty test tubes. There were no records of work done by the students or of attendance at lectures or clinics."

Universal Chiropractic College.—"They are not in any way equipped to give the character of instruction that would make their graduates safe advisers to the sick."

Palmer School of Chiropractic.—"They pretend to give a course in obstetrics with no practical experience. A person who assumed to practice on information gained from this course alone would be dangerously incompetent.

"Some of their professors are exceedingly ignorant. The 'professor' of chemistry alleged he taught the 'Widal test' chemically, but chemicals for even ordinary tests were not in evidence: those in evidence showed no marks of use, most of the bottles being still sealed.

"The institution is not physically equipped to turn out safe graduates."

A letter from Dr. J. M. Baldy, president of the Pennsylvania Bureau of Medical Education and Licensure, to whom the manuscript of this article was submitted, states as follows:

"The data quoted from our inspection is correct. I have gone over it myself and have submitted it to the inspector."

It is sufficient to say that the three schools are uniform on the following points: None has a library, a hospital, a laboratory that is worthy of the name, postmortems or capable teachers. Add to this farce students without preliminary education beyond the mere ability to read and write and who "graduated" after a course of only one year in one of these "colleges," and we have an individual who is hopelessly handicapped for life, one who cannot in any sense be considered a safe adviser of the sick.

These reports set forth everything with painful exactness and embarrassing detail. Any patriotic legislator will be justly incensed at the thought of taking the intellectual refuse from these schools who are not permitted to practice in Iowa, to be used in his own state as the guardians of life and health. They should not be given legal recognition to practice in any state. If they are permitted to practice, it should be only after they have obtained the same professional and preliminary training that is required of physicians, which in Iowa is a high school education and two years of collegiate work plus four years of professional training in a medical school that maintains a standard satisfactory to the licensing board.

Inconsistency of the Antivivisectionist.—Of course there are all sorts of men among physicians and surgeons as in all other professions. Abuses and outrages do occur, no doubt. There have been wicked doctors who have abused their trust; and there have been clergymen with whom the virtue of a young lady boarder was not safe; but we need not say for this reason that all surgeons are arch torturers and that all preachers are arch-lechers. Just as you do not need to pass a special law against adultery by ministers of the gospel, but that if you did so you would put an imputation on the character of a large body of earnest, sincere and unselfish men, so you should not pass laws which would put on men in biological research the imputation of bad faith and cruelty. Make the general laws against cruelty to animals as strict and far-reaching as may seem necessary for the good of the human race; but do not single out the men who are devoting their lives to the search after that knowledge which is for the best good of the race, and make them the special objects of unnecessary restrictive limitations. If experiments on animals must be prohibited let the same law prohibit castration of animals and the dehorning of cattle. If the English law requiring all operations by a scientific man to be done under anesthesia be adopted, then require that operations on the farm be performed in the same way.—Maxwell, *Science.*

RECTAL AS A SUBSTITUTE FOR VAGINAL EXAMINATIONS IN LABOR

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In spite of the most rigorous regard to the details of asepsis in the preparation of the patient, of the attendant's hands, and of the supplies which may directly or indirectly approach the two, the dangers of puerperal infection have not been reduced to that negligible degree which our profession should attain. Since the days of Carl Braun, various authorities have recognized the dangers accompanying vaginal examinations, have strenuously demanded the diminution of their number, and have sought means whereby such curtailment might be possible. All modern authorities are agreed that vaginal examinations, no matter with what conscientious regard to aseptic technic they are conducted, carry with them their risk of sepsis. Today it is generally recognized that abdominal palpation, aided by a proper interpretation of clinical evidences, offers as much, if not more, certitude as to the condition of the woman and progress of labor than do vaginal examinations alone. The elimination of the necessity of entering the vagina, or at least reducing the frequency to the point at which imperative exigency demands it, will be a distinct obstetric advance. In this paper, I would show that rectal examination fulfils this purpose, and that rectal will secure as much definite information, in most particulars, as do vaginal examinations, and without the risks of infection which inevitably accompany the latter.

When ventral fixation was a popular procedure, I found it expedient, in a number of women in labor, to endeavor to reach the cervix by rectal palpation. This was merely applying a method resorted to in gynecologic cases when, as in virgins, it was impracticable or impossible to use the vaginal route. However, this did not suggest the full value of the method in the conduct of labor. Two or three years ago the broader application was grasped from a source not determined. At first, used in an incidental manner, then as a routine, an experience matured which has convinced me that it was an invaluable method of investigation. Now, I am certain that rectal examination, supplementing abdominal palpation, should largely supersede vaginal touch in the conduct of *normal labor*, and in certain pathologic cases to be hereinafter mentioned; the latter route should be reserved solely for those cases in which the findings are inconclusive, or as a preliminary to operative work through the parturient canal.

Rectal, as a substitute for vaginal examination, was suggested by Kroenig,[1] Nov. 20, 1893, in a paper read before the Obstetric Society of Leipzig. The method was introduced in his clinic early in August, 1893. The midwives quickly developed a facility in the procedure, so that in the three months covered by his report, 90 per cent. of all labors were conducted by rectal examination alone. He deduced the following conclusions:

1. Midwives could palpate the spines of the ischia, determine the movability of the coccyx, and estimate the degree of resistance of the perineum.

2. They could determine whether the presenting part were in the pelvis or not.

1. Kroenig: Zentralbl. f. Gynäk., March 10, 1894.

3. They could recognize the sutures of the forelying head.

4. They could determine the relationship of the crown of the head to the bisischiatic line.

5. They could determine the dilatation of the os definitely in multiparas. In primiparas, errors were apt to occur, when effacement was completed.

6. Generally the fontanels were not to be differentiated.

7. The promontory was palpable only when a high grade of pelvic contraction existed.

Independently of Kroenig, Emil Ries,[2] now of Chicago, began an investigation of the possibilities of rectal examination, in January 1894, in the Strassburg clinic, and published his results a few weeks after Kroenig. The possibilities of the method were largely determined by Kroenig through the work of the midwives. Therefore, we have conclusive evidence of its worth as a means for general application. Ries' deductions were fixed largely by the results obtained by his own personal experience. As a consequence, his findings are more valuable, more comprehensive and more utilitarian for the working needs of the medical attendant. He corroborates the teachings of Kroenig, but has determined the far wider range of its applicability than Kroenig concedes for the method. Ries has presented the only extensive monograph on the subject, an opinion based on a very cursory review of the literature. Only one American textbook on obstetrics mentions the utility of rectal examinations, in a paragraph which includes four or five lines. F. Menge[3] gives an adequate interpretation of the application of rectal examination. He says, "If one combines it [abdominal palpation] with rectal examination, then after a little practice, one is able to judge in every single case all diagnostic and prognostic details with certainty, even if the case comes after the onset of labor." He further recommends that a single vaginal touch is to be undertaken only when the combined external palpation and rectal examination is not clear in every particular.

That the logical position of rectal examination may be properly presented, I shall give the usual factors which must be determined by routine vaginal exploration. These are taught in most recent textbooks, and are the factors which essentially are to be determined by the new method of investigation. At this point I can but mention the necessity of a definite procedure with every woman who presents her case to the obstetric attendant: The physician should make it an invariable rule to study carefully every woman by repeated abdominal and pelvic examination during the months of pregnancy, in order that he may be conversant with her normality or abnormality, so he may properly and intelligently supervise the labor.

FACTORS TO BE DETERMINED

Vaginal examinations in pregnancy, as we have learned by precept and example, should comprehend the determination of the following facts:

1. The pelvic size, its normality or abnormality.

2. Soft parts: their normality or abnormality: (*a*) the perineum; (*b*) the vagina; (*c*) the cervix and os; (*d*) recognition of tumors in or about the lower segment — placenta praevia, etc.; (*e*) the rectum.

3. The fetus: presentation and position; the cephalopelvic adaptability.

Further, in labor additional data must be determined:

4. The fetus: (*a*) revisional diagnosis of presentation and position, which must be made because many of the deviations from the normal are the products of labor; (*b*) the station of the presenting part; (*c*) the fact of compound presentation, as prolapse of the arm, leg or cord; (*d*) fetal deformities.

5. The effacement of the cervix, and dilatation of the os.

6. The status of the membranes.

Of course, in the event that the woman is first seen with labor in progress, all the foregoing data must be determined at the first examination, and may demand a vaginal examination.

There may be no question of the expediency of combining external palpation with vaginal examination *in pregnancy*, for then, carefully conducted, in a cleanly manner, the danger is negligible. To control the vaginal findings by rectal touch, in pregnancy, will convince the most skeptical of the desirability and reliability of the latter, and will manifest to him the certitude and conclusiveness of the knowledge obtained by it. The information obtained by these means, and properly recorded for reference in labor, will determine with definiteness the potential possibilities of the safe passage of the child. Therefore, in labor, only the supplemental factors have to be elicited by a pelvic examination — and they may be conclusively fixed by rectal touch.

The Pelvis.—The configuration of the posterior half of the pelvis may be outlined with clearness, in many respects with a precision that is impossible vaginally. The contour of the sacrum, its irregularities and relation to other osseous structures may be determined; the position and movability of the coccyx are evident. The spines of the ischia may be palpated, and their influence on labor may be approximated, as in the case of the ischia themselves. I cannot concur in Ries' contention that the anterior pelvic half may be palpated as definitely rectally as vaginally. Likewise, I have not convinced myself that the diagnosis of pelvic size is easily feasible rectally, though I do not doubt that some resourceful mind will discover a practical means of determining the conjugata diagonalis, even the vera, rectally. I have not been able to determine the diagonal conjugate, though the cephalopelvic relationship may be judged with a certain precision.

The Soft Parts.—Generally, the condition of the soft parts may be determined with the same accuracy as by the vaginal examination; the perineum may be studied with clearness, the texture of the vagina and of the cervix may be readily estimated, and the important data appreciated. The progress of the effacement of the cervix may be observed, and the degree of dilatation of the os measured; the clearness of recognition is particularly evident if the cervix is directed posteriorly. It is a clinical fact that effacement of the cervix and dilatation of the os occur synchronously in multiparas. In primiparas, the rule is for effacement to occur; then dilatation follows. Therefore, it is more easy to recognize the degree of dilatation in multiparas. In primiparas, the difficulty of appreciation is due to the fact that the thinned cervix fits snugly over the bulging membranes without a thick ring to designate the os. As Ries has well pointed out, by pal-

2. Ries, Emil: Zentralbl. f. Gynäk., April 28, 1894.
3. Menge F.: Winckel's Handbuch der Geburtshülfe, i, Part 2, p. 1208.

pating the cervix at the height of a contraction, little will be felt; in the interval of contraction, the lessened tension of the membranes will allow an indefinite band to develop which represents the boundary of the os. He also shows that the degree of dilatation is of relatively slight importance. Its size merely designates, to a certain extent, the progress of labor. An emergency which imperatively demands immediate operative intervention is not influenced by the fact that the os is dilated two or four fingers — a dilatation must be consummated artificially. The employment of this method has not been occasioned in placenta praevia, but, *a priori*, its recognition by rectal means would be influenced by the same factors which would permit its easy or difficult palpation vaginally. Often, a tumor may be outlined better by rectal examination than vaginal.

The Fetus.—In the majority of cases the diagnosis of presentation and position may be made without difficulty, providing the presenting part be within the pelvic cavity, that is at least engaged; often, it is surprising with what degree of certainty the sutures and fontanels may be palpated. This is especially true after material dilatation has occurred. Unquestionably, the facility with which they may be recognized rectally is directly commensurate to the ease with which they may be differentiated vaginally. We all occasionally encounter women in whom it is well nigh impossible to recognize the landmarks of the fetal head on account of the advanced ossification, or from marked overriding of the bones the result of excessive molding, or a tense caput; or, finally, the pelvic floor may be so tense that it precludes proper digital exploration. In such, when conditions demand certainty of diagnosis, and external palpation is difficult or impossible, the necessity arises of passing the hand into the lower uterine segment, under deep anesthesia, before the position may be accurately fixed. In such cases, the rectal offers no more indefiniteness than the vaginal route. It has not been my fortune to encounter a compound presentation, during the period I have employed the method as a routine, but I am convinced that it will offer almost the same certitude of recognition as will the vaginal examination, especially if the compound presenting part be laterally or posteriorly directed. It has been determined that the maneuvers of Müller and Kerr may be applied through the combined abdominal and rectal palpation when the vaginal is replaced by the latter. This is of fundamental importance, in labor, when the woman has a pelvic contraction and it is necessary to determine approximately the cephalopelvic adaptability when a cesarean section is under advisement. The station of the presenting part, whether floating, fixed, engaged or deep in the pelvis, all may be as positively estimated by rectal as vaginal examination. Ries has found that the pulsations of the cord in the vagina may be felt through the rectovaginal septum. Even the still cord may be outlined in the same manner, showing the possibilities in the diagnosis of a prolapsed cord.

The Membranes.—If there is any distention of the amniotic sac by liquor amnii it is possible to determine the fact. In a few instances it has been possible to rupture the membranes by firmly pressing on them through the rectovaginal septum at the height of a contraction. If there be a very scanty amount of forewater, or it is practically absent, one necessarily must be kept in ignorance; but it has happened in a few instances (as in oligohydramnios) that the only way to determine the presence or absence of the amniotic sac is to open the vagina widely with specula and inspect the head to ascertain if it be covered with the chorion.

Nowhere does the efficiency of rectal examination stand out so distinctly as in the control of women who have a relative indication for cesarean section. In such, it is not good obstetrics, usually, to perform the section until by a test of labor it has been positively proved that the disproportion is so material that an intact, living child cannot pass. We all know that the surest prognostic aid in determining the outcome of a cesarean section is the fact that vaginal examinations have or have not been made within a period of two or three days of the operation. It cannot be reiterated too often and emphatically that the contamination produced by one or more vaginal examinations during the labor influences the outcome of a cesarean section more unfavorably than does any other factor except exhaustion or ill-advised attempts at delivery. It is possible to determine the nonengagement of the head by abdominal palpation and rectal examination with absolute positiveness: therefore, it is utterly needless to enter the parturient canal during the period of watchful expectancy.

Rectal examination at or near term is by no means the obstetric limit to the procedure, for it is efficacious at any period of gestation. In threatened abortion, or abortion in progress, the rectal touch will furnish many of the data requisite for an intelligent conduct of the case up to the point of operative intervention.

TECHNIC

The woman should be given an enema before examination. Preferably, she should be on a table, or at least she should lie across the bed in the lithotomy position, with the buttocks quite to the edge, so the gluteal groove will not be in a depression of the bedding. A sterile rubber glove should be employed, for even though the finger enters a contaminated cavity it is not good practice to use a glove which may have infective matter on it. The finger should be anointed with sterile petrolatum or other unguent, and then should be passed through the anus slowly and carefully. At the same time the other fingers should be flexed in order that they may not accidentally enter the vulvar orifice. The various movements of the fingers should be slowly made, that the minimum of discomfort may be caused. Rarely will there be any pain, even if hemorrhoids are present; in fact, the average discomfort is no greater than when a vaginal examination is made. Generally, the rectovaginal septum is so lax that the examining finger may move with great latitude. The only time I found the method positively indefinite was in a woman who had had proctitis, with secondary contraction of the wall.

DANGERS

Very possibly objections to the method may be developed in the course of a broader experience — objections which may be valid in a very circumscribed field, and limited, in all probability, to conditions in the rectum itself. As we now see it, the danger is that the inexpert may allow the fingers or thumb to slip within the introitus during certain manipulations. This will be entirely obviated by keeping them flexed. The method is contraindicated when the termination of the labor is imminent, for fear, if haste is necessary, the attendant might forget to change the glove, or which is

quite as bad, attempt to wash the glove on his hand. The glove, after use, invariably should be boiled. Preferably, this glove should not be used in the conduct of the labor, even though it has been sterilized by prolonged boiling. In the old days when the method was introduced there was an obvious objection to it, as the examining finger necessarily was fouled, and sterilized with difficulty. Esthetically, also, it was not agreeable to contaminate the finger with fecal matter. Today, with the use of rubber gloves, there can be no such objection.

The basic principles on which this paper is founded were obtained in the course of my personal experience and practice. In substance they form the essentials of my teaching of pelvic examination in the class room. In the obstetric clinical instruction of the students of Rush College, rectal examination is practiced nearly to the exclusion of vaginal examination. Those who have charge of this work are convinced that the students have had no sacrifice of a means of teaching since vaginal examinations were eliminated. On the contrary, with the increased license of examination, the students have had an increased opportunity of pelvic investigation.

Since Dr. N. Sproat Heaney introduced this procedure in the dispensary clinic, the students have enormously augmented their practical knowledge of the phenomena of labor — are infinitely better placed than were the students who were permitted to make a limited number of vaginal examinations in a former period.

CONCLUSIONS

1. The discovery of the possibilities of rectal examination in labor by Kroenig and Ries is one of the most important contributions to modern obstetric medicine of the last generation.

2. There must be a complete revision of the chapter on pelvic examination in obstetric textbooks. Adequate presentation of the value of rectal examination must be stated. Vaginal examination should be made subordinate to rectal touch.

3. While, at the present time, rectal examination does not give us the means of measuring pelvic size, it is of great value in estimating the factors situated in the posterior half of the bony pelvis.

4. In almost every direction, under appropriate conditions, rectal examination is as definitive as vaginal, if combined with abdominal palpation.

5. The ease or difficulty of rectal examinations are commensurate to the ease or difficulty which encompass the vaginal ones, and are dependent on the same factors.

6. Rectal examination is an utterly innocuous procedure in labor, whereas, vaginal examinations are always potential sources of infection to the woman.

7. Rectal examinations are peculiarly appropriate to those women who are to receive the test of labor in relatively contracted pelves when a cesarean section may possibly be needed.

8. Vaginal examinations should be made in labor only when, for some special reason, the rectal findings are indefinite or inconclusive.

9. The least that can be said of rectal examination is that it permits the conduct of normal labor with the essential elimination of vaginal examinations: a decided advance in the technic of the conduct of labor.

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THE RAT A CARRIER OF A DYSENTERIC AMEBA*

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The purpose of this communication is to record observations incriminating the rat (*Mus norvegicus*) of a possible new rôle in the dissemination of disease, the details of which go to show that:

1. The rat (*Mus norvegicus*) suffers from spontaneous amebic dysentery similar to that occurring in man.

2. This apparently occurs in endemic foci in Charleston, S. C.

3. The ameba found in the cases of rat infection here reported are indistinguishable from *Endamoeba histolytica*.

4. This rat may be infected with *Endamoeba histolytica* by allowing it to eat human feces containing this parasite.

5. The disease thus produced is practically the same as that occurring in man and from spontaneous infection in rats.

6. This infection, spontaneous and experimental, may be transmitted from the infected to the healthy rat by close association, that is, living, eating and drinking together.

7. The rat is a possible and probable disseminator of dysenteric amebas pathogenic for man.

The details of the study from which these conclusions are drawn are as follows:

During the course of experimental transmission of the *Trichomonas intestinalis* to rats by feeding them human feces containing these parasites,[1] a large brown rat was given feces containing *Endamoeba histolytica* in addition to the trichomonas. At the end of three weeks the rat was noticed to be getting thin in spite of good feeding, and to be sluggish whereas he had been active and vicious. His emaciation became more noticeable in the course of a few days, and at the end of a month he appeared to be very sick and had developed a mucous diarrhea. This passed fecal matter, when examined fresh and warm, contained, in addition to the trichomonas and leukocytes, desquamated epithelium and shreds of intestinal mucosa, and red blood cells, numerous active and resting amebas identical with those in the feces with which he was fed. His feces as well as that of all the other animals used in this study had been examined for amebas before feeding and none found. His symptoms, sluggishness, dyspnea, turning of the hair, loss of appetite and diarrhea continued until he died on the thirty-second day after feeding.

Postmortem examination revealed a general anemia, acute mesenteric lymphadenitis, late perilobular cirrhosis of the liver with microscopic periportal abscesses in which no cells like amebas were found, jaundice of the liver and kidneys. The condition of the liver was probably due to the extensive infiltration with cysticerci and secondary infection. The following was the condition of the alimentary canal.

Stomach: Considerable mucus formation, otherwise normal.

Small intestine: Distinct acute catarrhal enteritis, fluid mucinous contents, no ulceration, no amebas present but many lamblias.

* Read before the Medical Society of South Carolina, Nov. 15, 1915.

1. Lynch, K. M.: The Trichomonas as a Parasite of Man and Certain Lower Animals, Tr. Pan-American Med. Cong., 1915.

Cecum: Semifluid yellowish mucinous contents containing the *Trichomonas intestinalis*, epithelium and mucosal portions, red blood cells, leukocytes, and large numbers of active and encysted amebas. The wall was the seat of an acute ulcerative inflammation practically identical grossly and microscopically with the more acute type of human amebic colitis, with irregular ragged undermined acute ulcerations, having necrotic edges and containing fecal matter and granular detritus in which the amebas were very numerous, and between which the mucosa was the seat of an acute catarrh.

Remainder of the large intestine: Acute catarrhal colitis, no ulcers, contents the same as that of the cecum.

The amebas in this animal and in the feces with which he was fed were recognized as *Endamoeba histolytica* by the following distinguishing features, according to Craig.[2] Size, from 20 to 60 microns; pseudopodia, large and blunt or slender finger-like; active; ectoplasm distinct, nongranular, refractive; endoplasm, granular, containing numerous noncontractile vacuoles and occasionally a red blood cell; nucleus indistinct; when at rest possessing a distinct clear shell enclosing the hyaline refractive body; with Wright's stain, ectoplasm dark blue, endoplasm light blue, nucleus pale red or pink.

This occurrence brought to my mind the habits of the rat, and his liking for feces and also for almost any and all of our food and drink. Failing to find any record of experimental transmission of dysenteric amebas to rats, although it has been done with other animals, notably kittens,[3] I instituted experiments to determine whether it could be done with any constancy by feeding, as this method alone could be of importance in incriminating the animal of possibly disseminating the infection.

To date I have fed about twenty rats with feces of as many human beings containing dysenteric amebas, active and in the resting stage. These include both the brown rat and the pet white rat (*Mus norvegicus*). Four of these have followed the same course as the first, that is, at about the end of the first month after feeding, they became sick, showing dyspnea, loss of appetite, emaciation, turning of the hair, and sluggishness, and developed a mucous diarrhea from an acute ulcerative inflammation of the cecum and acute catarrh of the remainder of the intestine. Some of them died after a few days of the well-marked symptoms, while others were killed for purposes of better study. Amebas identical with those administered were recovered from the large bowel, particularly the cecum, to which the ulceration was limited. While all of them exhibited this ulceration of the cecum, in some it was more severe and diffuse and acute than in the others and in the usual human case. None have shown any involvement of the other organs except in the nature of toxic degenerations. Three of these rats were white and the fourth brown.

What will occur in the remainder of the animals under experimentation remains to be seen, as none have yet arrived at the usual time of onset of symptoms.

In order to determine whether the infection could or would be transmitted from rat to rat, feces of the first were fed to another, and this one became sick with the usual symptoms at the end of two weeks, exhibited the ameba in stools and cecum, died shortly and showed an acute diffuse ulcerative inflammation of the upper large intestine. Sufficient time has not yet elapsed to show whether the third in this series, which was fed the feces of the second, will suffer in like manner. Also, a noninfected rat was placed in the cage with one which had been fed, but some time before it developed any symptoms of disease, to see if possible contamination of food and drink would infect the other. One of these developed the disease and died of it ten days after its fellow had suffered a like fate.

For the purpose of obtaining wild rats for the work, and also with the hardly formulated idea of searching for spontaneous amebic infection, these animals were trapped in different sections of the city of Charleston. The first source, a grain house on the water front, proved free of the infection. I have had about fifty rats from this place, have killed a number for examination, and failing to find amebas in them, have selected all those used for the feeding experiments from this source.

The first rat caught at the second place and brought to me after it had been killed exhibited as typical an example of amebic inflammation of the cecum as I have seen in a human being. Other than being less acute, and it must be remembered that the animal did not die of it, the lesion was practically the same as that seen in the first experimentally produced. The ulceration was limited to the cecum, was of irregular serpiginous character, undermined, with ragged edges, contained granular material and fecal matter, and the intervening mucosa was the seat of a subacute catarrh. The small intestine was not altered, and the lower large intestine had suffered a very mild catarrh. The content of the large bowel was softer than usual, but the stool well formed.

An ameba indistinguishable from the *Endamoeba histolytica* was present in the large intestine, a few in the rectum, many in the cecum, and large numbers in the material from the ulcers. It possessed the characteristics in size, activity, differentiation of ectoplasm from endoplasm, indistinctness of nucleus, appearance of pseudopods, resting stage, and staining properties. After direct comparison of the parasite obtained from this rat, and from others hereafter mentioned, to *Endamoeba histolytica* from human beings and experimentally infected rats, I am unable to tell them apart and conclude that it was *Endamoeba histolytica*.

The house in which this rat was caught was a negro habitation in a negro community, and while it had water closets and sewer connections, unfortunately these things do not always mean proper sewage disposal among these people and in such houses in Charleston. I have learned of a house within a few numbers of this one in which the water closet had been out of use and the several families living there using a basement for the purpose for some time. I also know of a case of amebic dysentery which came from this locality, apparently originating there. The suggestive relationships are obvious.

From this place, I have since obtained another rat in the same condition as the first; and from feeding the cecal contents of the first to two young white rats, have been able to produce the same condition in them as occurred in the previously described experimental

2. Craig, C. F.: Entamoeba Tetragena as a Cause of Dysentery in the Philippine Islands, Arch. Int. Med., March, 1911, p. 362.
3. Sellards, A. W., and Baetjer, W. A.: Bull. Johns Hopkins Hosp., February, 1913, p. 45.

infections from human feces, the same colitis, diarrhea and ameba, and death at the end of about one month.

From two other localities of similar nature but in different parts of the city, I have obtained five other rats with amebic colitis, one from one place and four out of six obtained from the other. In these five the ulcers were small, irregularly rounded, with elevated undermined edges, only from three to six or eight in the cecum, and the remainder of the intestine normal. The same ameba was present, mainly in the resting stage in the rectum, but active in the cecum and especially in the ulcers. In another of the six, the ameba was present, and although there was some desquamation of epithelium and catarrh of the cecum and small points of microscopic erosion of the mucosa, there were no gross ulcers. None of these rats exhibited amebic infections of other parts of the body.

I am now undertaking a search for the extent of the distribution of this spontaneous infection, both in the city and in the rural districts, and am also looking for possible human endamebic intestinal infection from the same localities, an indication of which is already given in the case from the second place mentioned.

At the same time the experimental work will be continued and any further observations made known.

The *Endamoeba histolytica* is a frequent inhabitant of the intestine of the negroes in Charleston. The possible relationship is interesting.

The rat has a liking for human feces and he is no respecter of our food and drink. Stiles[4] believes that man may become infected with lamblias through eating food which has been soiled by the excrement of rats. The important possibility of the same manner of transmission of dysenteric amebas to man is obvious.

Stiles fails to mention any knowledge of amebas in rats; neither have I found it recorded from any other source.

The burden of the sins of the rat and this menace to the health of man seem certainly increased by the incriminating evidence included in these observations.

SYPHILITIC IRITIS WITH CONDYLOMAS

REPORT OF THREE CASES

WALTER BAER WEIDLER, M.D.
NEW YORK

The three cases here presented are of such a nature that many authors would regard them as gumma of the iris; but as all of these lesions were seen during the secondary stage of syphilis, it would seem that they should be more properly diagnosed and classified as papules or condylomas of the iris.

Papular iritis is often called iritis gummosa. This is because papules of the iris were always regarded anatomically as gummas, and it is often impossible to differentiate between these syphilitic formations even with the microscope. I believe that in the very virulent or malignant form of syphilis, it is possible to have true gumma of the iris during the secondary stage. It would seem that it is more a matter of size and the period of its appearance that makes one lesion a papule and the other a gumma. It is my opinion that gummas are rarer than papules. The papules often occur in numbers, whereas the gumma is single and perhaps more often seen near the ciliary body.

4. Stiles, C. W.: The Rat and Its Relation to Public Health, Publication, U. S. P. H. S., 1910, p. 89.

CASE 1.—Mr. J. T., aged 45, chauffeur, had chancre of the penis seven months before he came to the Manhattan Eye and Ear Hospital, Dec. 2, 1913, with the history that for the past ten days the left eye began to be red and painful. He had no treatment for the eye conditions and only a short period of treatment for the syphilitic infection. There was considerable photophobia and lacrimation, and the lids of the left eye were kept closed. There was considerable haziness of the cornea, more pronounced in the lower half. There was a very severe congestion and engorgement of the superficial and deep ciliary vessels, giving a violaceous color to the pericorneal region. The iris was muddy and discolored. The pupil was contracted and did not respond to light, accommodation or convergence; but the tension was normal. The vision was reduced to counting of fingers at 3 feet. There was a condyloma of the iris down and in, and it seemed to be in the anterior portion of the iris stroma. It was grayish-yellow, about 5 mm. at its base, extended forward in the anterior chamber and was in contact with the posterior surface of the cornea. There were a number of small blood vessels visible over the growth.

The Wassermann test was positive (++++). The patient refused to have an injection of neosolvarsan, and was put on the iodid-mercury treatment, and after ten days the mass began to get smaller, the pupil began to dilate somewhat, the cornea was entirely clear, the bulbar congestion was much less, and the iris about the same color as its fellow. The condyloma or papule reduced to one fourth of the original size, and two weeks later the eye was absolutely quiet within a vision of 20/20.

Fig. 1.—Left eye; growth was down and in, reaching forward to posterior surface of the cornea. Pupil contracted and did not respond to light.

CASE 2.—Mr. L. M., colored, aged 23, elevator man, gave the history of having chancre on the penis seven months previous, and has been under treatment for syphilis at St. Luke's Hospital, receiving mercurial injections. Presented himself at the Manhattan Eye and Ear Hospital, Feb. 27, 1914, stating that twelve days before the right eye began to give him pain and this was accompanied with photophobia and lacrimation. He had no treatment at any time for the eye conditions. There was at this time considerable swelling of the lids with marked photophobia and lacrimation. The cornea was clear, there was a very pronounced pericorneal injection, and the deep ciliary vessels were very much engorged. The eye was very tender over the ciliary region. The aqueous was clear, the anterior chamber normal, and the general appearance of the stroma layer of the iris was unchanged, except up and out, where the stoma was decidedly elevated. At the pupillary edge of the iris, up and out, there was a whitish-gray exudate which seemed to protrude between the stroma and retinal pigment layer of the iris. This exudate had apparently attached itself to the anterior capsule of the lens, and the mass was protruding forward into the anterior chamber about 3 mm. There was only this single papule or condyloma with slight or no inflammatory changes in the iris. The vision of the right eye was 20/40 ??, of the left eye 20/20. The pupil was 3 mm. and did not react to the light, showing the presence of synechiae. The von Pirquet was positive, and there was the history of one of his brothers dying of tuberculosis. The Wassermann test was also positive (++++).

March 15, 1914, neosalvarsan was given, and the photophobia, lacrimation and pain entirely disappeared in thirty-six hours. The superficial and deep injection was much less. The tumor mass was rapidly reduced to at least two-thirds

its former size, and the pupil dilated fully and freely. There are still the synechial remains on the capsule of the lens, but no trace of the condyloma remains.

CASE 3.—Mr. P. E., aged 26, Irish, gave a history of having chancre about three months before and had taken treatment for syphilis for a few weeks. He came to my clinic at the Manhattan Eye and Ear Hospital. There was some swelling of the lids of the right eye, marked pericorneal injection involving the ciliary vessels. The cornea was slightly hazy, and the aqueous cloudy. The iris showed effects of inflammation, being discolored and the pupil 2.5 mm. Down and out there was a circumscribed elevation about 3 by 4 mm. at its base and about 2.5 mm. high, extending forward toward the posterior surface of the cornea but not in contact. This mass was pinkish-gray, and no distinct vessels were noted; but there was apparently some synechia formation. There was some photophobia and lacrimation. The Wassermann test was positive (++++). Two days later neosalvarsan was given, and after thirty-six hours a decided decrease in the size of the condylomas was noted. Inside of four days there was almost complete absorption of the mass. The iris cleared and the inflammatory symptoms were entirely relieved. A small synechia remains on the outer side of the iris above the location of the condyloma.

The very rapid response of this special syphilitic lesion in Cases 2 and 3 to the neosalvarsan was remarkable, and its use would seem to be especially indicated in this sort of syphilitic manifestation.

The diagnosis of the syphilitic lesions of the iris has been made much easier and surer by means of the serologic test. Where a definite history of the syphilis can be obtained, diagnosis of these lesions is a simple matter; but in the cases in which such a history is not obtained, the Wassermann reaction has added a most important factor in the diagnosis. It might be well to mention here that at times it has been difficult to differentiate between a papule or condyloma and a tubercle of the iris. It is in this sort of a case that the von Pirquet test and the subcutaneous tuberculin test become of great importance. Recently I have seen several cases of tubercle of the iris which have been treated for syphilis of the iris in spite of a negative syphilitic history and a negative Wassermann reaction with no improvement. For those who have not been especially interested in the tuberculin tests and therapy, I can readily see why such a line of treatment would be persisted in. It might be argued that previous antisyphilitic treatment has been employed; hence the negative Wassermann; or that the patient may deny syphilis for reasons best known to himself, and therefore without any further search for the cause, antisyphilitic treatment is used.

Fig. 2.—Right eye; growth was up and out, but did not reach to the cornea as in Figure 1. There was a grayish white exudate between the retinal pigment layer and the stroma of the iris.

The microscopic examination of the iris and the ciliary body when affected with gumma or condyloma reveals about the same changes as are noted in chronic inflammation of these tissues. There is nothing definite and characteristic which would make it possible to say that syphilis was the factor which caused the growth. The blood vessels show fairly constant involvement and microscopic changes in syphilis of the iris. There is an endarteritis especially of the smaller vessels with an apparent increase of the endothelial cells. This is partly due to the increase of pressure on the highly sensitized cells which line the lumens of the vessels. The adventitia also shows a proliferation or new deposition of cells with a marked increase of epithelioid cells outside of the adventitia.

Fuchs found the iris of normal thickness infiltrated with round cells, and these chiefly in the anterior limiting membrane. This inflammatory exudate of the leukocytes was also in the reticulum, and in some of his cases he found typical giant cells present. The presence of giant cells has been noted by other observers, but in none was there any caseation present. There are always a number of capillaries seen inside or around these syphilitic nodules, which is not the case in the tubercular nodules of the iris.

131 East Sixtieth Street.

SUPPURATIVE CHOLECYSTITIS FROM THE PARATYPHOID BACILLUS

REPORT OF A CASE

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Fellow of the American College of Surgeons; Professor of Gynecology and Dean, Vanderbilt University, Medical Department

NASHVILLE, TENN.

History.—The patient is married, aged 25; occupation, electrician. His family history is unimportant, except that he had one aunt on the paternal side who died of tuberculosis at the age of 40. He had the usual diseases of childhood, including spinal meningitis. He never had pneumonia, typhoid fever, tonsillitis or rheumatism. At the age of 13 he developed malaria of the tertian type, which recurred for three summers. He uses tobacco to excess, and occasionally beer and whisky. Venereal history is negative. About once a year he becomes badly constipated, and this is usually associated with cramps in the abdomen. These cramps continue for several days, unless relieved by a purgative. His digestion has always been perfect. There is no history of any accident or injury, although he has a cataract of his left eye, which has produced a loss of sight in that eye.

Monday morning, Aug. 16, 1915, he went to his work in his usual good health. In two hours' time, however, a severe headache came on, which was followed by pain in the abdomen and this in turn by nausea. He continued at his work, however, for the remainder of the day and returned home about 5:30 p. m. About 6 o'clock the pain in the abdomen was so severe that he called his physician, Dr. W. E. Reynolds. After making a careful examination, Dr. Reynolds told him that his symptoms were suspicious of intra-abdominal trouble, and asked to bring in a surgeon as a consultant, to which the patient consented. I saw the patient for the first time in consultation with Dr. Reynolds about 9 p. m. He was then complaining of pain on the right side of his abdomen. The temperature was 102 and the pulse was 100. An abdominal examination showed a marked rigidity of the right side and a localized tenderness most acute mi lway between the navel and costal margin, about 2 inches from the median line. He had, however, some tenderness all over the right side. The symptoms were rather suggestive of appendicitis, but we decided to wait until morning. Meanwhile he was ordered to abstain from all food, liquids or medicine. He continued to suffer in the night, and the next morning when his physician saw him, a localized pain was found in the region of the gallbladder. This pain continued with moderate severity during the forenoon. When the physician examined him again at midday, it was discovered that the localized pain had shifted from the region of the gallbladder to the region of the

appendix. The temperature at this visit was 101, and the pulse had gone up to 120. He was advised to go to the hospital for a more careful study of his case, and an operation, if necessary.

He was brought to my infirmary about 8 p. m. His pain was somewhat better, although there was a marked rigidity on the right side and a point of acute tenderness two finger breadths beneath the costal margin on that side. A urinalysis was made, which was negative. Blood examination revealed: hemoglobin 85 per cent., white blood cells 12,000. Temperature, 99.6. We had now had the case under observation for twenty-four hours, and as no appreciable improvement was present and as the symptoms were very suggestive of an intra-abdominal lesion, either the appendix or the gallbladder, an operation was advised, to which the patient consented.

Operation and Result.—A right rectus incision was made in order that a thorough exploration could be carried out. The appendix was enlarged and somewhat inflamed. We felt, however, that this could not be the entire cause of the trouble, and further search of the abdominal viscera was instituted, although the appendix was removed. The gallbladder was found in a state of marked distention. It was quite red, covered with lymph in numerous areas, and on the fundus were several small patches that were almost black. A needle was introduced, and about 5 ounces of cream-colored pus were drawn off. The gallbladder was then packed off, opened, cultures from the interior were taken, and a drainage tube inserted and the abdomen closed. The next morning the patient stated that he had been perfectly comfortable since he regained consciousness. The temperature, however, was 102, but the pulse had dropped to 100. The drainage from the gallbladder was copious and of a black color.

For the next few days the patient continued to feel well. His abdomen was flat and he complained of no pain at all except a headache. The temperature continued to run between 103 in the afternoon to 101 in the morning. On the fifth day after the operation the temperature was 104 and a blood count was made which was as follows: red blood cells 6,200,000; white blood cells 8,000. A careful examination of the patient's throat, lungs and abdomen was made, all with negative result. The Widal was also negative. The laboratory report at this time had not been received, and for this reason we were unable to account for the continued temperature with almost a normal blood count. The temperature continued to drop gradually, and reached the normal on the morning of the tenth day after the operation. It continued to run up in the afternoon for four days, ranging from 99 to 100.2. Fourteen days after the operation, for the first time, the temperature remained normal for the whole twenty-four hours, and continued to do so for the remainder of the patient's stay in the hospital. The wound healed by first intention, the tube was removed at the end of the tenth day, and the drainage tract was closed at the end of three weeks. At the end of five weeks and a half the patient returned to his business, feeling in first-class condition, although a little weak.

Laboratory Report.—The following report was received from the Department of Bacteriology, Vanderbilt University, Medical Department:

"Cultures made from the pus obtained from the gallbladder showed that there was but one organism present. This organism was found to be a short bacillus, irregular in length, actively motile, and gram-negative. When grown in litmus milk the medium became acid after twenty-four hours, but by the twelfth day had become alkaline again. The milk was not coagulated. There was marked gas formation after twenty-four hours in glucose bouillon. On Russell's medium the surface was bluish-white in appearance, while the lower layer became red and contained considerable gas. On endomedia the colonies formed a pale, bluish-white, translucent growth.

"The bacillus was not agglutinated by stock serums which had been obtained from patients suffering from infection with the typhoid bacillus and with the paratyphoid bacillus B, but was strongly agglutinated by the serum from a patient suffering from infection with the paratyphoid bacillus A.

"The serum of the patient did not agglutinate stock culture of the typhoid bacillus or the paratyphoid bacillus B, but did agglutinate the paratyphoid bacillus A, in a dilution of 1:200.

"From the cultural reactions and the agglutination tests, the organism isolated in pure culture from the pus is probably the paratyphoid bacillus A."

COMMENT

The interesting feature of the case was the early involvement of the gallbladder, as the first symptoms presented by the patient were due to the cholecystitis. I am unable to find in the literature of paratyphoid how early and how often cholecystitis occurs. With the typhoid bacillus it is not unusual, but comes up later in the disease. I am of the opinion that a careful culture made in all cases of noncalculous suppurative and gangrenous cholecystitis will clear up, to a great extent, the uncertainty concerning the etiology that now exists in these conditions.

PAINFUL WEAK FEET

REPORT OF CASE

H. WINNETT ORR, M.D., LINCOLN, NEB.

Many persons with very flat feet have no discomfort whatever. They have no foot strain, and strain is what causes all, or nearly all, the distress and secondary symptoms in these cases. Conversely, in those who have pain, to relieve the strain is to cure the patient. Usually, a period of rest, a change of shoes (especially shoes that are too tight, too narrow, or too short) "arch supports," or more scientifically constructed braces, or a combination of several of these measures, will afford the patient great relief. I encounter a considerable number of patients, however, who have tried all of the above methods and who are still not relieved.

CASE REPORT

History.—A young man, 23 years of age, consulted me last July with a history of disability on account of painful feet, which had been increasing for about three years. From January to July, 1915, he had been able to do only three weeks' work at his trade, that of a foundryman. His feet were swollen and acutely tender. He had leg ache, with pain in the knees and hips. At times there was much cramping of the muscles of the legs—so much sometimes that he could not sleep at night. He had a family dependent on him and was extremely anxious to resume work. The feet were markedly everted and there was pronounced spasm of the peroneal muscles. He came to me seeking braces, but I dissuaded him from this and advised tenotomy of the peronei with a period of fixation of the feet in inversion in plaster of Paris.

Operation.—He accepted this advice and the operation was done the next day. An attempt to forcibly invert the feet under anesthesia before tenotomy was not successful. Accordingly all of the peroneal tendons were divided just back of the external malleolus and then the feet could easily be strongly inverted.

Plaster casts were put on with the feet in this position and the patient kept in bed for about two weeks. Then he was allowed to get around, still wearing casts for a total of six weeks. During the seventh week after operation the casts were removed, ordinary shoes were put on, and he went home.

Result.—He now (November, 1915) reports that at first he walked with his feet in an extremely inverted (overcorrected) position, but that there is only a slight tendency in that direction in one foot at present.

He stands and walks perfectly well and can even walk on tip toe (an impossible feat for most of these patients). He

also relates that one day recently he husked corn for an entire afternoon. He wore ordinary shoes, following the wagon over rough ground with no discomfort except that he felt a little tired afterward.

He is resuming his work as a foundryman less than four months after operation and following three years of great disability.

A comparison of results by this method with those of other methods—especially forcible correction without tenotomy—leads to the conclusion that peroneal tenotomy (or, perhaps still better, resection of a portion of the peroneal tendons as suggested by Robert Jones) is much superior. The operation must, of course, be carefully done under strict asepsis and the after-care faithfully carried out or it will not fully succeed. If properly done, however, great relief may be had for a class of patients who suffer great distress and extreme disability, and who will not be relieved in any other way.

REPORT OF A CASE OF MERCURIC CHLORID POISONING

WITH PARTICULAR REFERENCE TO ITS TREATMENT

HARRY M. KAY, M.D., MADISON, WIS.

C. W., man, aged 47, July 3, 1913, at 2 p. m., took five tablets, 7½ grains each, of mercuric chlorid. Fifteen minutes after taking this drug, he was attacked with a desire to vomit and barely reached the toilet room when violent vomiting began. Three or four spasms occurred at the same time, and profuse perspiration started. This continued for about fifteen minutes, when there was a respite of about ten minutes. Then another attack of violent vomiting occurred, this attack being accompanied by simultaneous involuntary movements of the bowels. This lasted for about thirty minutes. His mouth began to fill with frothy saliva which, when expectorated, would remain connected to the mouth by a silver thread. Attacks of vomiting and diarrhea, less violent, continued to recur at longer intervals. The movements of the bowels took place at intervals of fifteen or twenty minutes. About 8 p. m., the patient drank some cold water, which seemed to give him considerable relief. During the entire night, he was subject to occasional spells of vomiting and involuntary movements of the bowels.

July 4, vomiting was much less frequent. The bowels still moved involuntarily, and there was continuous salivation. Sweating ceased during the night. Cramps did not recur. The patient drank some lemonade at noon and again at night; this seemed to give him considerable relief.

July 5, the symptoms continued, but were less violent, vomiting occurring but four or five times a day. In the morning the patient drank a pint of cold milk; at noon-time, he took lemonade; between times, ice-water; at evening, a bottle of beer.

July 6, vomiting had almost ceased. There was one movement of the bowels.

July 7, the patient felt considerably better. There was one attack of vomiting. Salivation still continued. The bowels moved about every hour; the stools were of the consistency of mucus and blood. Defecation was painful.

July 8, the patient did not vomit. The diarrhea was continuous. The stools were bloody, as on the previous day.

The foregoing history was obtained from the patient two months later.

July 8, five days after he had taken the poison, I was called to see the patient. His appearance much resembled that of a person in a uremic condition. He was semiconscious; he would answer an occasional question and go back to his partial slumber; the pulse was 120, temperature 99.4, and respiration 12. The patient gave me a history of *complete anuria for five days.*

The patient was taken to the hospital. On arrival he was immediately given a hypodermoclysis of 3,000 c.c. normal salt solution and put in a hot pack for twenty minutes. Catheterization resulted in 1 ounce of bloody urine. There was a good reaction from the skin. Profuse perspiration lasted about half an hour. During the night the patient slept very little. One of the troublesome complications with which we had to deal was hiccups; the patient hiccuped constantly during four days and nights; this was controlled somewhat by an occasional hypodermic of 1/100 grain of nitroglycerin.

July 9, the patient was again catheterized, and 2 ounces of urine resulted. Examination showed a faint trace of albumin, and a few pus cells and blood cells. There were no casts. Specific gravity was 1.008.

Every day for the ten following days, he was given from 2,000 to 3,000 c.c. normal salt solution hypodermoclysis and about the same quantity of normal salt solution proctoclysis. Following the hypodermoclysis, daily, the patient was put into an electric bath cabinet for from twenty to thirty minutes. The reaction of the skin was very marked. The patient was returned to bed and placed between blankets and the perspiration continued for two or three hours. The patient was catheterized the first three days, but on the fourth day he voluntarily voided 4 ounces of urine. The examination of this urine showed considerable albumin, and many granular and hyaline casts. The blood pressure at this time was 180 mm.

On the fifth day, the patient voided 10 ounces of urine, on the sixth day 15 ounces, and on the seventh day 20 ounces. From then on, the voidance of urine was about normal. The continuous examinations showed albumin, and also numerous hyaline and granular casts. When the normal flow of urine was established, he experienced relief from considerable pain in the region of the kidneys which had persisted since the early stages of the case.

During the first two weeks of his stay at the hospital it was necessary to give considerable attention to the condition of the bowels. The first few days there was a constant diarrhea, the stools having the consistency of mucus and blood. This we tried to correct with large doses of bismuth subnitrate and sodium bicarbonate. Later, constipation followed and was treated with mild enemas.

The mouth, also, was a source of great trouble. Fortunately, the patient had a partial plate which was removed and the gums treated. There was also constant salivation. Burning of the mouth was treated with alkaline mouth washes and also some potassium chlorid solution. The cardiac weakness and special symptoms were treated according as they developed. No morphin was given at any time. Occasional doses of 5 grains of veronal were given.

Diet consisted of milk, egg albumin, cereals, cream toast, etc.

The patient left the hospital July 22, apparently in good condition. The urinary examination at that time showed traces of albumin, a few blood cells and an occasional granular cast. Blood pressure was 130 mm., leukocytic count 8,000, red cells 4,300,000. Two weeks after the patient's discharge, he was back at his work. About a year after his discharge, I was fortunate enough to procure a specimen of urine. Examination showed that there remained no ill effects from the poison. I have not seen him since, but recently heard that he is in Milwaukee going about his work regularly and apparently in perfect health.

I wish to acknowledge my indebtedness to Prof. A. S. Loevenhart and Dr. Leopold Schumacher for their assistance and cooperation during the progress of the case.

Tuberculosis Number.—The September number of the Illinois *Health News*, the official monthly bulletin of the Illinois State Board of Health, is devoted entirely to the cause, prevention and cure of tuberculosis. The pamphlet is written for the benefit of the laity among whom it is intended to circulate, and recites in easily understood language the facts concerning this disease. It contains a number of pointed cartoons which emphasize various phases of the tuberculosis problem that should appeal strongly to the readers of the bulletin. Emphasis is laid on the danger of employing or depending on any so-called cures for consumption done up in a bottle.

Therapeutics

TUBERCULOUS MENINGITIS

Before discussing this almost hopeless disease, a review of our present knowledge of the physiology of the cerebrospinal fluid will enable us better to understand the causes of, and the danger from, cerebrospinal pressure.

We may epitomize our knowledge of this fluid as follows:

1. The cerebrospinal fluid is a secretion of the cubical cells of the choroid plexuses of the lateral ventricles and of the perivascular lymph spaces.[1]

2. Some barrier prevents most medicaments from reaching the cerebrospinal fluid by way of the blood stream, though bile pigments and sodium salicylate have been found in the cerebrospinal fluid.

3. The whole normal quantity of cerebrospinal fluid may be secreted in three or four hours.[2]

4. Normally the fluid has free passage from the lateral ventricles to the third ventricle, then through the aqueduct of Sylvius to the fourth ventricle, and from there is distributed through foramina into the subarachnoid space, and from this reservoir over the cerebrum, the cerebellum and downward into the spinal arachnoid.

5. The fluid is absorbed from the cerebrospinal canal by both blood and lymph vessels, but is mostly taken up by the veins; hence any obstruction to the venous circulation in the brain or meninges is more serious than a lymphatic obstruction in the same region.

6. A slowly developing cerebral pressure (compression) is better tolerated than a rapidly developing pressure. Also, rapid loss of pressure (decompression) is often dangerous. There is danger, therefore, from too rapid injection of an antitoxin or other fluid, and there are sometimes serious consequences from a too rapid withdrawal of cerebrospinal fluid.

7. The symptoms of any form of meningitis are due to the toxins of the germ infection plus increased cerebrospinal pressure. If this pressure is sufficient to cause coma, repeated spinal puncture will relieve it, and such drainage is theoretically indicated. Of course, in spite of the relief from such pressure the patient may die of toxemia.

8. Phenol (trikresol) preserved serums for intraspinal use have some elements of danger, although they are used with impunity by some clinicians.

9. Brain tumors mostly cause increased cerebral pressure, not by their growth or by local pressure, but by obstructing venous drainage of the cerebrospinal fluid.[3] Edemas of the eye grounds and choking of the disks seem to be caused by pressure in the optic nerve sheath, due to venous obstruction.

10. Dandy and Blackfan[4] have shown that hydrocephalus may be of two types, due either to an obstruction to the outflow from the ventricles, or to decreased absorption from the subarachnoid space. They also have found that there is but little absorption of surplus fluid in the ventricles. Hence if absorption is delayed in the arachnoids, operative interference gives no outlook of success.

Meyers[5] has given a numerical classification of the etiologic factors, symptoms and signs of 105 patients with tuberculous meningitis. A brief review of these factors will be of interest. As to sex, they were equally divided. The ages varied from 5 months to 11 years, with about one-third of the patients between the ages of 2 and 3, while over half were between the ages of 2 and 5. The greatest number of these cases occurred in January and March (in Boston). The variations in the number of cases occurring in the different months would probably change somewhat with the region and the climate investigated; therefore a monthly analysis is of but little value. Meyers found that 38 per cent. of these children had had no previous diseases; in the remaining 62 per cent. measles had occurred more frequently than any other disease. The average duration of the disease from the time of the beginning of symptoms was seventeen days. Meyers thinks the disease is not so rapidly fatal as it once was on account of lumbar puncture being now more frequently done, thus preventing early deaths from cerebral pressure.

Lumbar punctures were done from one to seven times to a single patient. He finds that lumbar puncture prevents convulsions, which become rare in the clinical history of the disease thus treated. Meyers believes that the advantage of lumbar puncture is not only in relieving pressure, but also in eliminating a certain amount of toxin. He has not found unpleasant symptoms to occur from the withdrawal of even a considerable amount of spinal fluid, even though it was not under high pressure.

The rule of Meyers is to allow the spinal fluid to drain until it runs at the rate of from 10 to 12 drops per minute, and to draw off from 20 to 30 c.c. of fluid, depending on the pressure. Eighty per cent. of the cases showed increased pressure, but varying of course, in degree. If the child lived, lumbar puncture was done once every forty-eight hours. If the fluid removed at the first puncture did not show the organism causing the meningitis, the later punctures usually did, and tubercle bacilli were found in 21.5 per cent. of these 105 cases of tuberculous meningitis.

When there was no increase of pressure in the cerebrospinal canal, there were almost no disturbances of the reflexes, and there seemed to be no relation between the amount of pressure and the presence of convulsions, bulging fontanel or retraction of the head. The fluid in this disease was never found really turbid, and was generally absolutely clear. The cell count of the fluid varied from 24 to 960 per cubic millimeter, with an average of 198. This cerebrospinal fluid cell count seems to vary with the leukocyte count of the blood: the greater the leukocyte count, the greater the number of cells in the spinal fluid. The prevailing type of cell in the spinal fluid was the small mononuclear, ranging from 90 to 100 per cent. in 67 per cent. of the cases, and from 80 to 90 per cent. in 20 per cent. of the cases. A fibrin clot was found in 70 per cent. of the cases, and a positive globulin test in about 50 per cent. The globulin content seems to vary directly with the cell count. The first part of the spinal fluid withdrawn at each puncture has a different cellular con-

1. Weed: Jour. Med. Research, September, 1914.
2. Dandy, W. E., and Blackfan, K. D.: An Experimental and Clinical Study of Internal Hydrocephalus, THE JOURNAL A. M. A., Dec. 20, 1913, p. 2216; Internal Hydrocephalus, Am. Jour. Dis. Child., December, 1914, p. 406.
3. Frazier: New York Med. Jour., June 27, 1914.
4. Dandy, W. E., and Blackfan, K. D.: Internal Hydrocephalus, Am. Jour. Dis. Child., December, 1914, p. 406.
5. Meyers, A. E.: A Study of 105 Cases of Tuberculous Meningitis, Am. Jour. Dis. Child., May, 1915, p. 427.

tent from the last part that is withdrawn, the first part giving the greater number of cells.

One fourth of the cases showed a leukocyte count of the blood between 10,000 and 15,000; the lowest count was 8,500, and the highest 48,000. Absence of eosinophils, as in some other diseases, is considered an unfavorable symptom.

In those tested for the von Pirquet reaction, 63 per cent. were positive.

Twenty-five per cent. of the cases gave a history of definite exposure to tuberculosis. Thirty per cent. of the cases showed lung involvement, and had more or less cough. In 71 per cent. the eye reflexes were abnormal, but in 29 per cent. the pupils were equal, and reacted normally to light. Thirty per cent. showed normal patellar reflexes, and in 21 per cent. the reflexes were absent. There was a positive Babinski in 21 per cent. Fifty per cent. of the cases gave the Oppenheim sign. Ankle clonus was rarely present. Kernig's sign was present in 27 per cent. of the cases. Forty-three per cent. showed some signs of paralysis, with strabismus as the most frequent form. Seventy per cent. showed some rigidity of the neck, and, late in the disease, there was definite stiffening of the limbs.

While 39 per cent. of the patients had a history of convulsions before entering the hospital, as stated above, spinal puncture seemed to relieve or prevent convulsions. The subjective symptoms were drowsiness, indifference, and sometimes irritability. Eighty-five per cent. had vomiting as an initial symptom. This vomiting had no relation to the food taken, and in no case was there projectile vomiting as is so frequently seen in meningococcic meningitis. Pain was a frequent symptom.

In 18 per cent. of the cases the urine showed acetone, and sometimes slight traces of albumin.

Before death, pulse, temperature and respiration in about half of the cases became higher. Early in the disease the pulse was slow and irregular; later in the disease it became soft and rapid. In 64 per cent. of the cases there was a remission, with a drop in pulse and temperature; but this was apparently not a sign of improvement. Also, a patient, who may have been comatose, may brighten up and answer questions from twenty-four to thirty-six hours before death. Forty-two per cent. of the cases showed terminal bronchial pneumonia.

In no case in this series was there recovery. The treatment tried was sodium benzoate in large doses, and inunctions of mercury. Hexamethylenamin was used in large doses, but even with these large doses there was never a trace of formaldehyd found in the spinal fluid. This seems again to disprove the value of this drug in cerebrospinal inflammations.

CEREBROSPINAL MENINGITIS

The treatment of meningococcus meningitis was thoroughly considered in THE JOURNAL, April 3, 1915, p. 1158, and again on page 217 of "Prevention and Treatment of Infections."

The value of the Flexner serum continues to be shown, but it is not generally recognized that it often has curative value, even after the child has been sick with this disease for days and even weeks. Smith[1] reports five cases all cured by meningococcus antitoxin, and four of these patients had been sick four days, nine days, twenty days and twenty-three days, respectively. These five patients not only were cured, but they recovered without sequelae. The history of these patients and the results show the value of repeated injections of the serum, and also the value of withdrawing the cerebrospinal fluid at frequent intervals, even after the fluid has become clear and there are no organisms to be found either microscopically or by culture.

All nervous symptoms in these cases were ameliorated after lumbar puncture. The fact that as much as 80 c.c. of fluid was withdrawn at once shows that normal absorption of fluid is interfered with, and that the removal of the surplus fluid is life-saving.

Smith's finding bears out the clinical fact recognized before the discovery of the meningococcic serum that repeated spinal punctures and drainage in cerebrospinal meningitis frequently save life.

1. Smith, W. A.: Cases of Epidemic Cerebrospinal Meningitis Treated with Flexner's Antimeningitis Serum, Am. Jour. Dis. Child., May, 1915, p. 418.

New and Nonofficial Remedies

THE FOLLOWING ADDITIONAL ARTICLES HAVE BEEN ACCEPTED BY THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION. THEIR ACCEPTANCE HAS BEEN BASED LARGELY ON EVIDENCE SUPPLIED BY THE MANUFACTURER OR HIS AGENT AND IN PART ON INVESTIGATION MADE BY OR UNDER THE DIRECTION OF THE COUNCIL. CRITICISMS AND CORRECTIONS ARE ASKED FOR TO AID IN THE REVISION OF THE MATTER BEFORE PUBLICATION IN THE BOOK "NEW AND NONOFFICIAL REMEDIES."

THE COUNCIL DESIRES PHYSICIANS TO UNDERSTAND THAT THE ACCEPTANCE OF AN ARTICLE DOES NOT NECESSARILY MEAN A RECOMMENDATION, BUT THAT, SO FAR AS KNOWN, IT COMPLIES WITH THE RULES ADOPTED BY THE COUNCIL.

W. A. PUCKNER, SECRETARY.

OUABAIN, CRYSTALLIZED (See N. N. R., 1915, p. 103).—The following non-proprietary preparation has been accepted:

G. Strophanthin (Thoms), Merck.—Manufactured by E. Merck, Darmstadt, Germany (Merck and Co., New York).

MERCURY BINIODIDE OIL SOLUTION IN AMPULES, H. W. & Co.—One Cc. of solution contains red mercuric iodide in a neutral fatty oil, 0.1 Gm. (1½ grain). Each ampule contains more than 1 Cc.

(Accepted for inclusion in the appendix to New and Nonofficial Remedies.)
Prepared by Hynson, Westcott & Co., Baltimore.

MERCUROL (See N. N. R., 1915, p. 197).—The following dosage forms have been accepted:

Mercurol Tablets, ¼ gr.—Each tablet contains mercurol 0.016 gm. (¼ grain). Prepared by Parke, Davis & Co., Detroit.
Mercurol Tablets, ½ gr.—Each tablet contains mercurol 0.03 gm. (½ grain). Prepared by Parke, Davis & Co., Detroit.
Mercurol Tablets, 1 gr.—Each tablet contains mercurol 0.065 gm. (1 grain). Prepared by Parke, Davis & Co., Detroit.
Mercurol Tablets, 2 grs.—Each tablet contains mercurol 0.13 gm. (2 grains). Prepared by Parke, Davis & Co., Detroit.
Mercurol with Potassium Iodide Tablets.—Each tablet contains mercurol ¼ grain and potassium iodide 1 grain. Prepared by Parke, Davis & Co., Detroit.

IODALBIN (See N. N. R., 1915, p. 157).—The following dosage form has been accepted:

Iodalbin and Mercurol Tablets.—Each tablet contains iodalbin 5 grains and mercurol 1 grain. Prepared by Parke, Davis & Co., Detroit.

LIQUID PETROLATUM. — Petrolatum Liquidum.—Liquid petrolatum is described in the U. S. Pharmacopeia. For description see the Pharmacopeia or Useful Drugs.

Non-Proprietary Preparation:

Liquid Petrolatum Merck. — Liquid petrolatum made from American petroleum. It is colorless, nonfluorescent, practically odorless and tasteless. Specific gravity 0.855 at 15 C. or 0.846 at 25 C. It complies with the tests of the U. S. Pharmacopeia (8th ed.).
Merck & Co., New York.

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

535 North Dearborn Street . . . Chicago, Ill.

Cable Address . . . . "Medic, Chicago"

Subscription price . . . . . Five dollars per annum in advance

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SATURDAY, DECEMBER 25, 1915

On account of the large amount of space occupied by the Index in this issue of The Journal, certain departments have been omitted entirely and others abbreviated.

THE INDEX AND HOW TO USE IT

This number of The Journal contains the index to Volume LXV, July-December, 1915. If this were all the index contained, comment would be unnecessary. It is not, however, simply an index to the matter printed in The Journal, but covers also the articles that have appeared in the principal medical journals of the world — seventy-nine domestic and eighty-one foreign. It is a practical everyday working index to current medical literature, cross indexed by subjects, authors, etc. The preparation and issuing of such an inclusive index is a rather large undertaking. Those who have any idea of what this work means will appreciate this the more when it is realized that the index in this issue occupies 320 columns. Sometimes a doubt arises whether the index is fully appreciated by those who have occasion to look up bibliographic references. So many letters are received requesting The Journal to supply references to literature when the writer has the index at hand, that it is feared sometimes that readers do not fully realize its value.

To facilitate the use of the index it has been the custom to make a separate publication under the title, "Guide to Current Medical Literature." This includes, in addition to the index as it appears in this issue, the titles of articles arranged chronologically and by journals as they appear weekly in the Current Medical Literature department of The Journal.[1]

The loan feature by which our readers, for the sum of 6 cents in postage, may borrow certain foreign journals listed in the index is being appreciated more and more, and evidently is proving of great convenience and usefulness to physicians. There looms up the possibility that The Journal will be compelled to subscribe for extra copies of some of the more important foreign journals in order to supply the demand.

1. See advertising page 2.

RECENT ADVANCES IN KNOWLEDGE OF ALLERGIC PHENOMENA

An important step in the development of our knowledge of the phenomena of immunization was the demonstration that the treatment by injection of an animal with a foreign protein, bacterial or otherwise, leads to profound changes in the body which may endanger as well as protect the life of the animal when this protein is reinjected. These changes are characterized by the formation of antibodies which, while they increase the resistance of the animal against subsequent inoculations of toxins and microbes, certainly seem to render the body highly susceptible to poisoning in the instance of innocuous proteins. This apparent hypersusceptibility, which we speak of as allergy or anaphylaxis, may be so marked that a second injection of the foreign protein results in severe or even fatal injury to the animal. The clinical and pathologic picture of the allergic reaction suggests that the injury to the cells is due to a poisonous action, and an early explanation of anaphylactic phenomena assumes that under certain conditions toxic substances are liberated as a result of a reaction in vivo between the protein and its antibody. On such a hypothesis has been developed the widely accepted theory of parenteral digestion. Vaughan, using chemical methods, found that all proteins contain a similar poisonous group which can be liberated when the protein molecule is broken up. Furthermore, when this toxic product is introduced into an animal, a condition quite typical of anaphylactic shock results. Hence he concluded that protein sensitization is due to the development of a specific proteolytic ferment in the body which acts on the reinjected protein and liberates the toxic element. This supposition that a specific protease is formed when a foreign protein is introduced into the body has been developed also by Abderhalden and his associates. By the use of biologic methods, Friedemann and Friedberger were able to demonstrate that poisonous products could be obtained, for example, by treating red blood cells or bacteria with fresh unheated guinea-pig's serum (complement), and they thought that the toxic substance in anaphylaxis is formed from the antigen, and that in this process, which Friedberger assumed to be intravascular, the complement plays an active rôle. The fundamental hypothesis of the theory of parenteral digestion as developed by Vaughan, Friedemann, Friedberger and others has been generally accepted, but there is still much difference of opinion as to the matrix of the toxic fraction and the mechanism by which it is formed in the body.

While the principle that allergic phenomena are due to enzymatic proteolysis has been upheld, much doubt has been cast on the early assumption that the antigen furnishes the toxic product. Using insoluble substances such as agar, kaolin and barium sulphate instead of bacteria and red blood corpuscles, many

observers found that these substances when treated with horse serum and then with guinea-pig serum yield a poison similar to the so-called anaphylatoxin of Friedberger. Such experiments strongly indicate that the toxic product is formed by the action of the complement on the horse serum absorbed by these insoluble substances. Again, the observations of Jobling and Petersen, recently reviewed in these columns,[1] emphasize the importance of the proteins of the animal itself as the matrix of the poison in the allergic reaction. Jobling and Petersen find that bacteria as well as agar, kaolin and chloroform, when mixed with fresh guinea-pig serum, absorb the antienzymes normally in the blood and thereby render the serum toxic. They assume that poisons are formed because the nonspecific proteolytic ferments of the blood are liberated through the absorption of the antienzymes by the antigen injected, and now the blood proteins undergo digestion. Does the complement enter into these proteolytic changes? The experiments of Friedberger and others indicate that there is a diminution of the complement during protein intoxication, but there is no other evidence of a convincing nature to establish the assumption that it plays an active rôle in the proteolytic process.

As to the localization of the allergic mechanism, recent researches permit certain definite statements. The earlier investigators, especially Friedberger, explained anaphylactic shock as entirely due to an intravascular mechanism; but later work points to the probability that cellular reactivity is of the greatest importance. Pearce and Eisenbrey, using transfusion methods, and Schultz, Dale and Weil, using isolated muscle tissue of sensitized animals, have shown conclusively that the condition of hypersensitiveness is largely determined by an increased capacity for reaction on the part of the fixed cells to the specific antigen. In other words, allergy is largely due to a changed reactivity of the cells, occasioned, we may assume, by an excess of specific antibodies or enzymes in the protoplasm. Such a condition easily explains both the acute death in sensitized animals and also the local skin reactions that we ascribe to allergy. But the experiments of Biedl and Kraus, Friedemann and others afford evidence that all the factors necessary for the production of allergic reactions may be present in the blood stream; hence, in the light of these two lines of evidence, it seems logical to conclude that both fixed cells and the blood stream are capable of furnishing the necessary agencies in the production of protein intoxication.

Although there is a great mass of experimental data at hand pertaining to allergy and associated phenomena, the facts are not sufficient to warrant any very definite conclusions. The injection of a foreign protein into the body really does not render the body any more sensitive than before to that protein, but increases the power of reaction whereby the substance is more easily broken up. Furthermore, in this reaction changes take place of both a chemical and a biologic nature, a correlation of which is fundamental in the thorough understanding of the phenomena of anaphylaxis.

The application of the knowledge of the allergic phenomena to the study of bacterial infection and immunity is difficult, for numerous factors enter into the reaction which are not present in the instance of unformed proteins. Active sensitization of animals with bacterial proteins is not difficult to accomplish, however, and the treatment of bacteria in vitro with active serum results in the formation of acutely toxic products. Doerr considers the bacterial cell as representing a group of antigens which, when liberated by lytic substances in the body, are free to act as unformed proteins. Whether this explanation or that of Jobling and Petersen contains the solution of the problem, it still remains that whatever proteolysis takes place, toxic products may be liberated. Thus in acute infectious diseases the invading bacteria stimulate the production of specific antibodies, which react with the bacteria, leading to the liberation of protein constituents of the bacterial cell. On this basis the incubation time as well as the general reaction of the infectious diseases may be explained (von Pirquet). It is interesting to note that such an explanation would not be illogical in case of the acute eruptive diseases. The possibility of the development of complete immunity against unformed, primarily harmless proteins seems questionable, for it has been demonstrated that animals with high antibody contents in their blood die following subsequent inoculations of the antigen. But in the instance of cellular proteins, that is, microbes, a definite resistance is often developed which usually is characterized by a marked increase in the power of phagocytosis, a process the influence of which, if any, we are not able to trace in the reactions against unformed proteins.

1. The Antiferments of the Blood, editorial, THE JOURNAL A. M. A., Oct. 30, 1915, p. 1554.

NEW FOOD GRAINS—PROSO AND KAOLIANG

We are accustomed to novelties in drugs. Scarcely a week passes without the heralding of some new synthetic chemical compound, plant ingredient or animal tissue constituent to which therapeutic potency is attributed. It requires not only a clear memory but also a critical judgment to cultivate a progressive and proper attitude of mind in the midst of such incessant therapeutic suggestions. Far rarer are the proposed innovations in the domain of foods. Now and then some unusual fruit or nut or green vegetable is brought to the attention of the public; but our "staple" crops persist unchanged in popular favor. Corn, wheat, rye and potatoes each have a preferential place

in dietary esteem in different localities, depending on tradition and geopraphic and economic conditions. The praises of millet seed and sorghum grain as human foods have a truly novel ring, however, even in these days of possible shortage in the usual cereal food supply of some of the European countries.

Millet, as is well known, has been cultivated for forage and grain since ancient times. To Americans the name will at once suggest a fodder for animals, and its significance is not enhanced by the familiar designation of "hog millet." Professor Nansen[1] of the South Dakota Agricultural Experiment Station, who has investigated the possible use of millet as food for man, has suggested the substitution of "proso," the ancient Slav name for the grain. The seed of proso millet, although practically unknown in America as a food for human consumption, is a familiar article of diet in Russia and India. It is said that during the Russian famine of 1890 proso millet bread was for a long time the only food remaining between the peasantry and starvation. The grain can be milled and cooked in the same ways as are many other cereals. The composition of hulled proso is much like that of patent wheat flour, being even richer in protein. The grain can be used whole, ground like corn meal and thus made into palatable dishes, or used as flour. The lack of gluten makes it necessary to combine proso with wheat flour if it is to be converted into a good bread. A "public" test of proso as a table cereal was made at the South Dakota State College of Agriculture early in the present year, so that it has already experienced an "official introduction." From the standpoint of practical agriculture proso deserves consideration because, like kafir corn, it represents a crop which can be produced in dry seasons or in arid regions where the attempts to raise the more popular cereals are often discouraging.

Another plant product tested for its possible usefulness as a human nutrient is kaoliang, a drought-resistant grain sorghum long used in Africa, India and parts of Asia.[2] This plant, once a tropical annual, also can by careful selection be extended as far north as Indian corn on this continent. Specimens of hardy kaoliang from China reached America as early as 1866, but were discarded because they seemed of no value for sugar making, the only use to which the sorghum plant was put at that time. This sorghum seed can be milled; and when mixed with gluten-yielding flours kaoliang contributes to the production of palatable baked products as does kafir flour which has lately been exploited as a human food.[3]

Variety in diet is a physiologic desideratum, and changes in our food staples occasionally become a climatic, agricultural, or economic necessity. Sometimes revolutions occur in the domain of popular nutrition. The potato was introduced in this way. We must at least be equipped with detailed information of the increasing dietary and culinary possibilities in this field.

1. Nansen, N. E.: Proso and Kaoliang as Table Foods, South Dakota Agric. Expt. Sta. Bull. No. 158, March, 1915.
2. Ball, C. R.: The Importance and Improvement of Grain Sorghums, U. S. Dept. Agric., Bureau Plant Industry Bull. 203, Washington, 1911.
3. See U. S. Dept. Agric. Farmers' Bull. 559, 1913.

THE EFFECT ON THE OFFSPRING OF LEAD POISONING IN THE FATHER

In articles on industrial lead poisoning, it is usual to find the statement that this form of intoxication results in fetal death and in death of offspring soon after birth, not only when the mother is the victim of the poisoning, but also when the mother is normal but the father "leaded." As far as maternal lead poisoning is concerned, there seems to be abundant evidence that women who work in lead are far more likely to abort than are women in ordinary factory work. Legge[1] abstracted from the reports of British factory inspectors for the year 1897 the following statistics concerning women lead workers: Of 77 married women, 15 were sterile; among the 62 who became pregnant, 15 never bore a living child. The stillbirths numbered 21, the miscarriages 90; 101 living children were born but 40 of them died, leaving 61 living children as the result of 212 pregnancies. Another striking report comes also from the British factory inspection service. Oliver[2] quotes Reid's figures as follows: For 100 mothers engaged in housework, there were 43.2 miscarriages and stillbirths; for 100 mothers engaged in mill work, not lead, 47.6; for 100 mothers, in lead work before marriage, 86.0; for 100 mothers, in lead work after marriage, 133.5. Tardieu[3] reported to the French government in 1905 that 608 out of 1,000 pregnancies in lead workers resulted in abortion. Animal experiments also, carried on by Oliver, by Glibert, and by Legge and Goadby, show that death of the fetus may be produced by poisoning the mother with lead.

In those countries in which many women are employed in the lead industries, these facts are of great importance and have resulted in laws forbidding the employment of female labor in certain processes. In the United States, few women employees are exposed to lead poisoning, and we are more vitally interested in the question whether or not paternal plumbism has any effect on the germ. The conscientious seeker after evidence will find far less to support the theory of paternal influence than of maternal; indeed, he will wonder at the positiveness on this subject shown by many textbooks on industrial diseases. There is the report of Chyzer[4] which is often quoted, concerning degeneracy among the children of Hungarian potters. But pottery dipping is a house industry in the Hungarian villages, and there is ample opportunity both

1. Legge: Jour. Hyg., 1901, i, 96.
2. Oliver: Brit. Med. Jour., 1911, i, 1906.
3. Tardieu: Poisons industrielles, Paris, 1905.
4. Chyzer: Chir. Presse, Budapest, 1908, xliv, 906.

for maternal poisoning and for poisoning of the children after birth. A few statistics are furnished us from France. Rudeaux[5] in 1905 stated that out of 442 pregnancies in women married to lead workers, 66 ended in abortion and 241 in premature birth. The most often quoted report on this subject is Constantin Paul's,[6] written in 1860. Lewin[7] seems to have borrowed it in 1904 and republished Paul's figures without quotation marks; and as German medical literature is read more than French in this country, the figures are almost always attributed to Lewin. They are as follows: Seven wives of lead workers who had given evidence of plumbism had 32 pregnancies, of which 11 ended in abortion, and 1 in stillbirth. Of the 20 children born living, 8 died in the first year, 4 in the second, 5 in the third and 1 after the third, leaving only 2 alive out of the 32 pregnancies.

This is, after all, slender evidence on which to base positive statements on so important a matter as the effect of paternal lead poisoning on the germ, and we are grateful for two experimental studies in this field which have just been published independently. Cole and Bachhuber,[8] working at the Wisconsin Agricultural Station, fed lead acetate to rabbits and fowls. Experiments with rabbits resulted in a mortality of young during the first four days after birth of 47.7 per cent. for offspring of leaded males as contrasted with 29.2 for the offspring of normal males. The average weight at birth was 49.8 grams for the former, 59.0 grams for the latter. With Leghorn hens the results were similar. When the hen was bred to a cock which had been fed lead acetate, 27.5 per cent. of the embryos in fertile eggs died and 14.1 per cent. of the chicks born alive died in less than three weeks, while the corresponding figures were only 17.2 per cent. and 3.7 per cent. when the cock was normal.

C. V. Weller[9] of the University of Michigan used commercial white lead — basic carbonate — and fed it in capsules to guinea-pigs. The experiments which interest us especially are those with leaded males, and these are some typical results which he obtained:

	Free Female Mated with:	
	Free Male	Lead Male
Number of offspring.....	58	65
Average birth weight, grams.	81.5	66.3
Number stillborn	3	3
Died first week.....	2	9

The effect of alternate matings of the same normal female with a normal and with a lead male is also interesting. For instance, the birth weights of the offspring of a free male were 79 gm. in two instances, and of a lead male 54, 47 and 40 gm.

The results of paternal lead poisoning in guinea-pigs are shown, not in sterility or in stillbirth, but in reduction of weight at birth, and this underweight persists through life. Next to this the most striking change is the high rate of mortality during the first few days after birth. Nine out of 65 offspring of leaded males died during the first week, but only two out of 105 offspring of control males.

In a lecture on industrial plumbism delivered in London in 1911, Thomas Oliver declared that from the purely physical point of view a nation's strength is measured by its reproductive powers and the high percentage of fitness of its children. He then went on to point out the danger to the race of industrial plumbism, especially as it affected potential mothers. In our country this danger is largely confined to men; but that it is a serious evil in our lead trades has been shown by numerous state and federal investigations. If we are to believe that this results in impairing the efficiency not only of this but also of the coming generation, it would make a strong argument for the legal regulation of the lead trades.

5. Rudeaux, quoted by Thompson: The Occupational Diseases, New York, 1914, p. 257.
6. Paul, Constantin: Arch. gén. de méd., 1860, i, 513.
7. Lewin: Berl. klin. Wchnschr., 1904, xli, 1074.
8. Cole and Bachhuber: Proc. Soc. Exper. Biol. and Med., 1914, xii, 24.
9. Weller, C. V.: Jour. Med. Research, 1915, xxxiii, 271.

PUTREFACTION, PHENOLS AND PROTECTIVE MECHANISMS IN THE BODY

It has long been known that when urines are distilled with a mineral acid, phenols may be recovered in the distillate. This result is obtained not only when phenol (carbolic acid) itself is absorbed through some channel into the circulation, but also under ordinary conditions of diet and health in which the antiseptic has never been employed. Baumann showed that in the urine itself the phenols are present in the form of ethereal compounds. Among these are the organic or "conjugated" sulphates and the glycuronic esters of the phenols. The fact that in "carbolic acid urines" the phenol occurs in the form of an ethereal sulphate early became a classic example of the detoxicating power of the animal organism. This was comparable with the protective reaction by which indol derivatives were found to be excreted as ethereal sulphates, particularly in the form of the clinically familiar indican of the urine.

At first it was believed that the phenol derivatives in the urine owe their origin to plant products in the food; for the urine of herbivora was observed to be particularly rich in its yield of the phenols. The progress in the study of the chemistry of putrefaction presently developed a new interpretation. In man the elimination of phenol was seen to be increased by a diet rich in proteins. The latter yield tyrosin, which can be converted into phenol and cresol by putrefactive changes. Here, then, was the key to the sequence of events. Proteins, tyrosin, intestinal putrefactive changes with production of phenols and their alimentary absorption, condensation to phenol esters, and excretion in the urine — these were the steps. Like indican, which owes its origin to the tryptophan com-

plex of the proteins, the phenols likewise became an index, so to speak, of putrefactive conditions in the bowel. By vigorous catharsis phenols are made to disappear from the excretions; whereas in severe constipation or intestinal obstruction they are reported to be increased in amount.

In the light of all this interesting information it seemed at first to be merely a question of expediency as to which of the various excretory products of putrefaction should be measured to furnish a helpful clinical guide to intestinal conditions. The indican tests, being easily applied, were earliest in use and still enjoy a widespread popularity. When they are "checked up" by estimations of the ethereal sulphate in the urine it is frequently found that there is a lack of correspondence between the two. Either other substances than indol compounds are eliminated as conjugated sulphates, or the indican precursor may find its way into the urine in a form other than sulphate. Both circumstances are known to occur. The phenols may add to the content of "ethereal" sulphate, and the indol derivatives may leave the body as glycuronates. And when it comes to a practical application of the urinary content of either phenols, indican or ethereal sulphates to the question of the extent of the putrefactive conditions in the bowel, experience has shown that the diet as well as the bacterial invaders plays a dominant part. If the food is deficient in protein precursors of these peculiar excretory products the latter are necessarily reduced in amount. Without a suitable pabulum the putrefactive micro-organisms cannot manifest their characteristic reactions.

In all of this development of our knowledge of the interrelations between putrefactive products and urinary derivatives, it has for the most part been tacitly assumed that the conversion of the harmful into the more harmless product is ordinarily quite complete. Certain it is that the ethereal sulphates of the urine are decidedly increased after the deleterious compounds have been introduced into the organism. Considerable interest will be awakened, therefore, by the recent communication of Folin and Denis[1] demonstrating that the phenols are by no means quantitatively converted into conjugated phenols in the body. This fact has been established by the use of an improved method of analysis.[2] The free phenols, of which the most important quantitatively is doubtless paracresol, represent from 30 to 90 per cent. of the total output. In addition to this unexpected finding, the excretion of total phenol products in the urine appears to be much greater than is indicated by the phenol figures heretofore recorded in the literature. The new data furnished by Folin and Denis indicate 0.3 to 0.5 gram of "total phenols" in a twenty-four-hour quantity of human urine. Normal human subjects (as well as larger animals) yield comparable figures, and those furnished by infants and children are proportionate. In some children there is little or absolutely no conjugation, the whole of the phenols being excreted in the free form. As the Boston investigators remark, this is unexpected when considered from the prevailing concept of the protective mechanism by means of which the phenols are supposed to be detoxicated through transformation into conjugated compounds. The phenol excretion tends on the whole to be much higher on protein-rich diets and lower on a regimen containing smaller amounts of protein.

The possible bearing of these newer discoveries on current conceptions of the pathology of nutrition is intimated by Folin and Denis. In general, they state, biologists are inclined to assume that the protective processes are adequate — that certain poisonous or deleterious substances are easily converted into harmless compounds; while the clinicians are constantly considering established or possible deficiencies and generally believe in "auto-intoxications" as an important feature in the etiology of diseases. The inadequacy of some of these supposedly perfect protective mechanisms hitherto championed by the physiologists has been brought to light in the case of the phenols.

1. Folin, O., and Denis, W.: The Excretion of Free and Conjugated Phenols and Phenol Derivatives, Jour. Biol. Chem., 1915, xxii, 309.
2. Folin, O., and Denis, W.: A Colorimetric Method for the Determination of Phenols (and Phenol Derivatives) in Urine, Jour. Biol. Chem., 1915, xxii, 305.

THE LIVER AND FAT METABOLISM

A considerable number of diseases either border on or are actually classified as attended with an infiltration of fat in some of the organs. The abnormal states of the body in which an infiltration of the liver, for example, has been observed include such diverse and unlike cases as diabetes, poisoning with phosphorus, phlorizin, chloroform or alcohol, emaciation, pernicious diarrhea, etc. A symptom which is common to such a variety of pathologic conditions cannot well represent the fundamental etiologic factor in each instance; on the contrary, it is far more likely that the common feature is the outcome of, or is conditioned by, some primary disturbing agency. As one of the authorities in this field says, the common factor of the above-named pathologic conditions "is undoubtedly a disturbed or deficient metabolism either of protein or of carbohydrate." In all these cases the fat reserves must be mobilized to supply material for the energy changes ordinarily furnished by the other foodstuffs.

Why the liver should be singled out so conspicuously for this "mobilization" of fat has long remained obscure. More recent comparisons of the fats ordinarily present in the hepatic tissue with those found in the usual fat-storage localities of the adipose tissue have furnished the clue to a possible explanation. The fat from the fat depots like the subcutaneous tissue, the omentum, mesentery, and adipose tissue about the

kidney consists essentially of the glycerids of fatty acids, such as palmitic, stearic and oleic acids. Of these the oleic acid is an "unsaturated" organic compound. Without elaborating the chemical details it may suffice to say that the content of unsaturated fatty acids in any fat is indicated by the amount of iodin it can absorb. The "iodin values" of the fats therefore have a useful significance in this respect. It appears that under ordinary circumstances the fats of the liver, heart and kidney have much higher iodin values than the fats which are deposited in the fat depots of the body and are derived directly from the food fat as well as by synthesis from other absorbed nutrients.

The unsaturated fatty acids are apparently more readily oxidizable than the normal compounds. Leathes[1] has expressed the view that the liver exercises the function of "desaturating" fats brought to it so that they are prepared for the subsequent metabolic processes. "It looks," he fancifully remarks, "as if the work of the liver consisted in an operation which may be compared to the drying of gunpowder. The fats we take in our food are remarkably unreactive substances, and it has always been one of the most astonishing chemical achievements of animal cells that they should be able to burn up completely and cleanly as they do so stable a structure as saturated fatty acids like palmitic or stearic acids. They are wet gunpowder. And the body stores its gunpowder wet, and safely removed from the inflammatory operations of busily working cells. When the orders for mobilization are issued this wet powder is conveyed to the drying chambers in the liver, and from there distributed to the fighting line in a proper condition for use. There are times when the stress of this work is manifestly too great. Too active a mobilization of stored fat, or too little activity in dealing with it on the part of the liver, will result in an accumulation of the unfinished product in that organ. A fatty liver is then the result, and the fatty acids which it contains are found to have a low iodin value. There is an accumulation of wet powder."

In harmony with the foregoing, Mottram[2] has recently pointed out that, in the case of infiltration, the fat is in the liver for physiologic, not pathologic, reasons. When there is need for fat for energy transformations, particularly when the other foodstuffs such as sugar are not available for nutritive purposes, the liver is found to be infiltrated with fats, presumably in order to be chemically transformed in some degree before they are handed on for use elsewhere. It is interesting to recall that absorbed food fat is not carried directly to the liver as the other digestion products are; but it enters the circulation directly by way of the thoracic duct and thus avoids the hepatic cells before it is carried to the storage places for fat. Mottram suggests that when energy is wanted by the body in a nutritive emergency as the result of some pathologic condition, it might be advantageous to save the liver the work of desaturation by feeding fats containing a high percentage of unsaturated fatty acids. These are found in some of the fish oils like cod liver oil, and in such food products as sardines and herring. Opie and Alford[3] have noted that ordinary fat is not an advisable food in conditions like chloroform poisoning, in which infiltration ordinarily occurs in notable degree.

The view which presents infiltration of the liver as a physiologic response rather than a pathologic consequence is supported in an indirect way by the usual absence of degenerative histologic features in this organ. It explains the fatty infiltration of the liver observed during late pregnancy and early lactation.[4] Evidently the fetus is greedy for unsaturated fats, which are worked up for its benefit by the liver.

It is generally accepted that acidosis, in the sense of ketonuria, is related in the body to the fats as its antecedent. Ketonuria occurs under the same conditions that manifest fatty infiltrations of the liver. When the isolated liver is perfused with fatty acids the acetone substances may arise. Mottram[2] postulates that just as the infiltration is an expression of a physiologic function (desaturation) in fat metabolism, acidosis leading to ketonuria is the result of the fatty acid pursuing an abnormal path of metabolism, possibly as a result of overwork of the liver. Either condition is relieved when carbohydrate is available. Whether the usefulness of unsaturated oils is likewise indicated, as has been suggested, remains to be ascertained.

1. Leathes, J. B.: The Functions of the Liver in Relation to the Metabolism of Fats, Harvey Lectures for 1908-1909, p. 213.
2. Mottram, V. H.: Fat Metabolism and Its Relation to Acidosis, Canadian Med. Assn. Jour., July, 1915.
3. Opie and Alford: Jour. Exper. Med., 1915, xxi, 21.
4. Cf. Coope, R., and Mottram, V. H.: Fatty Acid Metabolism in the Liver, Jour. Physiol., 1914, xlix, 23; 1915, xlix, 137.

Current Comment

THE BILE AND CHOLESTEROL EXCRETION

There appears to be little doubt at present that cholesterol (or, as it is sometimes designated, cholesterin) can be absorbed in the alimentary tract from such food intake as may contain it. This has been ascertained in particular from the fact that after suitable feeding of foods rich in cholesterol, the content of this substance in the blood may be increased. Cholesterol is found, among various tissues and fluids of the organism, in the bile. The origin of the biliary cholesterol, which betrays itself in a familiar pathologic way in the formation of gallstones, is by no means certain as yet. It may be derived from disintegrating red blood cells, or it may represent food cholesterol that is being eliminated in the only excretory fluid that contains a suitable solvent for it. Whether the bile presents a normal or physiologic mode of excretion for cholesterol has been much debated. In so far as

the evidence on this subject is derived from an examination of bladder or fistula bile, it must be remembered that the cholesterol thus found may have its origin in the walls of the biliary passages. Naunyn always defended the view that this is the case. Inasmuch as bile from the gallbladder is much richer in cholesterol than that from a fistula it was contended that this substance is added to the bile largely by the epithelium of the bladder. The evidence is, however, by no means conclusive. A number of feeding experiments have been undertaken by various investigators at different times to ascertain whether an abundance of cholesterol in the diet would be attended with an increase of the substance in the bile. The results, from which it was hoped to learn whether absorbed cholesterol would be excreted again in the bile, have been rather conflicting or indecisive. In the newest experiments conducted by D'Amato[1] at the University Medical Clinic in Naples, on dogs with biliary fistulas, it appears that a diet rich in food containing cholesterol does increase the content of cholesterol in the bile. But the increment is so slight and insignificant in comparison with the quantity of cholesterol fed that there is no real justification for the contention that the bile forms a prominent mode of excretion for the substance under discussion. Furthermore, there is no convincing evidence that cholesterol is converted, as some have assumed,[2] into cholic acid, which enters so largely into the make-up of the bile salts.

OSTEITIS DEFORMANS

Any disease which can claim a record of scarcely more than 200 authenticated cases in the modern literature of clinical medicine surely deserves to be classed among the rarer maladies. This situation applies to osteitis deformans, which Sir James Paget, who described it in 1876, termed a "rare disease of bones." Although in its advanced stages it presents an unmistakable clinical appearance, there have been comparatively few scientific investigations of osteitis deformans. Heredity, syphilis and other bacterial infections have at times been regarded as predisposing causes; but there is little to justify this belief in the light of more critical analysis of the case reports and laboratory findings. Neurotrophic factors have seemed to some students of the disease to be more likely causes of the bone dystrophy, perhaps because so little that is definite can be postulated in relation to the association of bone defects and nervous disorder. An opportunity to make a study of new cases of osteitis deformans has arisen at the Jefferson Hospital in Philadelphia. The unusual feature of the investigation there[3] is the detailed examination of the metabolism in two cases, one advanced and the other early. In the advanced case there was a pronounced retention of calcium, magnesium and phosphorus. This metabolic picture is thus to a certain degree the reverse of that seen in osteomalacia. In the latter disease, the skeletal structures of the organism have been depleted through the resorption of both organic and inorganic substances. Inasmuch as calcium is the principal element concerned in bone growth, the significance of the observed high retention of this element in osteitis deformans may be related to the abnormal development of certain portions of the skeleton. It must be stated frankly, however, that some students of the disease assert that the increased development of the bone or bonelike structure is not accompanied by the calcification of these parts, though the few available analyses tend to support the evidence of positive calcification. The association of acromegaly and gigantism with disease of the pituitary gland, and likewise the osseous lesions of cretinism in which the thyroid is unquestionably concerned, have justified the Philadelphia investigators in a hypothesis in regard to osteitis deformans. They recall that the interrelation of disorders of the bone metabolism and perverted function of some of the ductless glands has been verified in certain cases. This fact, together with other observed features of abnormal calcium metabolism, leads them to the belief that Paget's disease also is a disorder of bone metabolism probably dependent on the absence or perversion of some internal secretion. Every available opportunity in the future ought to be utilized to consider the etiology of osteitis deformans critically in the light of the suggestions here recorded.

1. D'Amato, L.: Uebt das in der Nahrung enthaltene Cholesterin einen Einfluss auf die Cholesterinausscheidung in der Galle aus? Biochem. Ztschr., 1915, lxix, 217.
2. Compare Grigaut: Le cycle de la cholestérinémie, Paris, 1913.
3. Da Costa, J. C.; Funk, E. H.; Bergeim, Olaf, and Hawk, P. B.: Osteitis Deformans: A Report of Five Cases with Complete Metabolism Studies in Two Instances and a Review of the Literature, Jefferson Medical College and Hospital Publications, 1915, vi, 1.

THE KIDNEYS AS A FACTOR OF SAFETY

"For a score of years, or more, in many of us the kidney is gradually losing some of its valuable material from one cause or another without any symptom, without a reminder sufficient to spoil our pleasure of life or to hamper our activities. Not until that luxurious surplus is approaching its exhaustion do we get a warning. But then our work is mostly done and our time limit nearly reached." This quotation, from a lecture by Meltzer[1] on the factors of safety in animal structure and economy, may serve to remind us not only that we are continually producing metabolic products which would be harmful if they were not promptly removed from the body, but also that our organism is doubtless absorbing substances from the varied intake of food mixtures which might be expected now and then to exhibit toxic effects, were it not for the efficiency of the excretory organs. In other words, it is not at all improbable that we frequently escape the detrimental possibility of ingested products because they are excreted so promptly and completely that they cannot accumulate in sufficient concentration to do harm in the body. The actual danger never reveals itself unless the eliminating organs have had their potency impaired in some way. An interesting illustration has recently been furnished

1. Meltzer, S. J.: The Factors of Safety in Animal Structure and Animal Economy, the Harvey Lectures, 1906-1907, p. 139.

by Smillie,[2] who has found that a potassium salt, such as the chlorid, in a dose which is harmless to normal individuals may be injurious in nephritis. Inasmuch as suitable patients may react to potassium chlorid without showing adverse effects from comparable quantities of sodium chlorid, the "salt action" cannot account for the effect. It may be assumed, therefore, in the constant presence of the chlorin ion, that the toxicity is due to the potassium ion. Smillie has found that rabbits die with great suddenness after an ingestion of 1 gm. (15 grains) of potassium chlorid, if they have acquired an experimental uranium nephritis of a degree sufficient to increase the nonprotein blood nitrogen to 100 mg. per hundred cubic centimeters. The fatal outcome is not due to "salt action" but probably to the action of the potassium ion on the heart muscle. Comparable acute poisoning was also observed in human nephritis. This acute intoxication occurs probably because the salt, which normally is readily absorbed and very rapidly excreted, in nephritis is readily absorbed but not excreted, thus reaching a concentration in the blood which is injurious. Such a demonstration is highly significant in its relation to the management of diet in nephritis. Some of our foods, notably the vegetables, are particularly rich in potassium. Smillie refers to a calculation indicating that a man who took a large part of his food in the form of potatoes might have an intake of ten times the fatal dose, calculated on the basis of experience on animals with kidneys removed. Bunge has actually reported taking more than half an ounce of potassium salts in a day. Were it not, says Smillie, for the fact that potassium salts are so rapidly excreted by the kidneys in health, the effects might be very serious.

2. Smillie, W. G.: Potassium Poisoning in Nephritis, Arch. Int. Med., August, 1915, p. 330.

COOPERATION IN INDUSTRIAL HEALTH INSURANCE LEGISLATION

At the request of the American Association for Labor Legislation, the Council on Health and Public Instruction of the American Medical Association has appointed a committee to assist in drafting a health insurance bill to be introduced into the legislatures in session in 1916. The committee consists of Dr. Alexander Lambert of New York, chairman, Dr. Henry B. Favill of Chicago, and Dr. Frederic J. Cotton of Boston. The preparation of this bill and the plans for its immediate introduction into several legislatures have removed health insurance from the realm of academic discussion and have placed it in the front rank of the pressing practical questions confronting the medical profession. The Association for Labor Legislation, which is responsible for this bill, has been influential in securing the enactment of workmen's compensation laws in thirty-three states within five years. It has also worked for protection against industrial disease, and drafted the federal law abolishing the use of poisonous phosphorus in matches. In its legislative program it has been backed by progressive employers, by representative labor leaders and by members of the medical profession interested in industrial diseases. Every extension of its activities in the field of industrial hygiene has made increasingly clear the absolute necessity for making systematic provision for sickness of working men, which is possible only through a comprehensive system of health insurance. In preparing its bill, which is the next step in health legislation, the association wisely has recognized that adequate medical care is of the first importance, both to the wage earner and to his family, and it has been equally wise in asking the cooperation of medical men in drafting those provisions which affect physicians. The certainty that such laws will be enacted within a few years, the success of the American Association for Labor Legislation in obtaining the legislation it advocates, and the consideration shown to the medical profession have convinced the Council on Health and Public Instruction that cooperation is desirable and opportune. This close cooperation will guarantee that the best interests of the medical profession under health insurance will be borne in mind at every step.

THE INCORPORATION OF THE AMERICAN MEDICAL ASSOCIATION

On last Monday, December 20, the Supreme Court of Illinois rendered a ruling — it was not a decision, as the newspapers stated, but simply a ruling — in the case of *Lydston* vs. *the State's Attorney*. The newspapers, in sweeping statements — inspired? — have carried the impression that the ruling is against the American Medical Association; that the officers, including trustees, are holding their offices illegally; that a new election must be held immediately, etc. Nothing could be farther from the truth. It is the old story; it is merely another step in the case started about the time of the meeting of the American Medical Association in St. Louis in 1910, at which time Lydston tried to compel the state's attorney to bring quo warranto proceedings against the Association. The American Medical Association has not yet technically been brought into the case; thus far the issue has been between Lydston and the state's attorney. The technical announcement of the ruling just made is *"Hoyne, State's Attorney,* vs. *People ex rel;* Lydston; petition certiorari denied." The state's attorney tried to get a decision from the Supreme Court, but the Supreme Court declined to hear the case at this time and therefore denied the writ of certiorari.

Foreign Technic.—In technic the general observation is made that the foreign operator does much more of his own work than is the rule with us. He assists himself notably. He often ties, cuts and sponges himself. Yet he obtains no small speed. His assistants are usually far better trained than ours because they work longer with him. Man or nurse, the same individual has learned to know, by years of association, just what the next need or move of the surgeon is to be, and the assistant, even when changed, as in Britain, does not stay less than six months, and is a senior on salary. The operator may even thread his own needles and lay out his own simplified outfit. Lessened infection is said to result from a minimum number of persons in contact with instruments, sponges and wound.—Robert L. Dickinson.

Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST; SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION, PUBLIC HEALTH, ETC.)

CALIFORNIA

Municipal Clinic.—A municipal clinic for the treatment of tuberculosis in Sacramento is practically assured. A site has been secured at Second and Q Streets, and the clinic will be opened early in the year.

Physician Wins Malpractice Suit.—In Judge Woods' court, November 12, a jury rendered judgment in favor of Dr. James C. Negley, Los Angeles, in the suit for $30,000 brought against him by Agatha Wells for alleged malpractice.

Hewlett to Succeed Wilbur.—Dr. Albion Walter Hewlett, formerly professor of internal medicine at the University of Michigan, Ann Arbor, was appointed, December 8, to succeed Dr. Ray Lyman Wilbur, president-elect of the University of California, as professor of medicine at Stanford University.

Hookworm.—The California State Board of Health will establish headquarters in Los Angeles for the study of hookworm disease which is said to afflict many of the miners in Southern California. The malarial belt of the Sacramento Valley will also be studied. Dr. James G. Cumming, formerly head of the Pasteur laboratory at the University of Michigan, Ann Arbor, has been appointed head of the laboratories in Los Angeles.

Head of Tuberculosis Bureau.—Miss Edythe L. M. Tate, executive secretary of the California Association for the Prevention of Tuberculosis, has won first place in a competitive examination held by the California Civil Service Commission for a position as director of the Tuberculosis Bureau of the State Board of Health, which carries with it a salary of $3,000. Miss Tate was largely instrumental in securing the passage of the law appropriating $75,000 to the Tuberculosis Bureau.

Personal.—Dr. Frederick Parker Gay, professor of pathology in the University of California, Berkeley, has been selected as faculty research lecturer for 1916 and will give the annual public address on the result of his own research in some special field at the University of California, March 23, 1916. Dr. Gay's selection was in recognition of his recent work in developing improved methods for the treatment of pneumonia and typhoid fever.——Dr. Norman Bridge, president of Throop Institute, Los Angeles, was the guest of honor at a dinner given by the Chicago members of the Alumni of Lake Forest College and representatives of the faculty of that institution at the University Club, Chicago, December 9.——Lillian J. Martin, professor of psychology at Stanford University, has been appointed head of the department of psychology, succeeding Dr. Frank Angel, who has resigned to take charge of the Belgian relief work in London and who sailed for the war zone, December 10.——Dr. Charles C. Landis, Chico, will leave for China next month. He will be located in the province of Hunan as a missionary of the Adventist Church.——Dr. Thomas A. Stoddard, Santa Barbara, has returned after several months' work in a British base orthopedic hospital, Liverpool.——Dr. Percy T. Phillips, Santa Cruz, has been appointed a member of the State Board of Medical Examiners, succeeding Dr. Frederick F. Gundrum, Sacramento, who resigned to accept appointment as a member of the State Board of Health.——Dr. Ray Lyman Wilbur, dean of the medical department of Stanford University, San Francisco, will assume office as president of the Leland Stanford Jr. University, January 1.——Dr. Josiah Morris Slemons, of the faculty of the University of California, has resigned to accept a similar position in Yale Medical School.

DISTRICT OF COLUMBIA

Diphtheria.—For the first ten months of 1915 there were 191 cases of diphtheria in Washington, with eleven deaths. During the same period of 1914, 100 cases were recorded.

Mental Hygienists Meet.—At the first meeting of the board of directors of the Society for Mental Hygiene of the District of Columbia, December 2, Surg.-Gen. Rupert Blue, U. S. P. H. S., was elected president; Mr. Cuneo H. Rudolph, first vice president; Dr. D. Percy Hickling, secretary; and Miss Nellie Sedgley, treasurer.

Personal.—Dr. D. Percy Hickling has been appointed chairman of the Public Health Committee of the Washington Board of Trade.——Dr. Edgar D. Thompson has been selected as president of the North Capitol and Echington Citizens' Association.——Dr. Philip Newton is reported to have been made corps surgeon in the Russian service.

District Society Election.—At the annual meeting of the Medical Society of the District of Columbia, December 1, the following officers were elected: president, Dr. Edward Y. Davidson; vice presidents, Drs. Joseph D. Rogers and Isaac S. Stone; recording secretary, Dr. Henry C. MacAtee; corresponding secretary, Dr. Arthur L. Hunt; and treasurer, Dr. Charles W. Franzoni, all of Washington.

Medal of Honor to Major Heller.—A bill has been introduced into the senate to authorize the secretary of war to award the congressional medal of honor to Maj. Joseph M. Heller, M. C., U. S. V., for unusual, distinguished and gallant action in attending the wounded under fire while a contract surgeon, U. S. Army, at the battle of Naguilan, North Luzon, Philippine Islands, Dec. 17, 1899, and during the months of September, October, November and December of the same year while attached to the first battalion, Twenty-Fourth United States Infantry, First Division, Eighth Army Corps, under the command of Maj. Gen. H. W. Lawton, U. S. V.

FLORIDA

Personal.—Dr. Grace Whitford, Ozona, has been appointed acting chairman of the health department of the Florida Federation.——Dr. Theodore G. Croft has been appointed city physician of Jacksonville.

New Officers.—Duval County Medical Society at Jacksonville, December 7: president, Dr. James H. Pittman; vice president, Dr. W. Williams McDonell, and secretary-treasurer, Dr. Herbert O. Black, all of Jacksonville.——Hillsboro County Medical Society at Tampa, December 7: president, Dr. Louis S. Oppenheimer, Tampa; vice president, Dr. John W. Alsobrook, Plant City; secretary, Dr. Earle H. McRae, Tampa; and treasurer, Dr. William C. Douglass, Tampa.——Pinellas County Medical Association at Clearwater, November 11: president, Dr. Franklin W. Wilcox; vice president, Dr. Alvin J. Wood; secretary-treasurer, Dr. William McK. Davis, all of St. Petersburg.

GEORGIA

Personal.—Dr. Howard J. Williams has retired after twenty years' service as a member and president of the Macon Board of Health. At the last meeting which Dr. Williams attended, he was presented with a loving cup by members of the board.—Dr. Alfred F. White, Flovilla, has been appointed a member of the State Board of Medical Examiners, to succeed himself.——Dr. Olin H. Weaver has been appointed chairman of the Macon Board of Health.

ILLINOIS

Personal.—Dr. William E. Range, Glen Carbon, has been obliged to go to the Southwest on account of the health of his wife.——Dr. and Mrs. J. L. Huntington, Princeton, have decided to locate in Santa Barbara, Calif.

Quarantine Lifted.—Three counties of Illinois have been freed from quarantine for the foot and mouth disease and the quarantine in six other counties has been modified by an order from the Department of Agriculture, effective December 18. This order releases from quarantine the counties of Dupage, Livingston, Marshall and all of Cook County, excepting the Union Stock Yards, which remains a restricted area for handling animals for immediate slaughter.

Chicago

Inspecting the Children.—The health commissioner suggests that to supplement the efforts to improve the public health by inspection of the schoolchildren, the thousands of children gathered in the Sunday schools, particularly during the holiday season, should likewise be inspected. He suggests that the pastors of the churches throughout the city and the superintendents of Sunday schools invite local physicians to look over the Sunday school classes on Sunday mornings or afternoons to determine whether any of them suffer from communicable diseases. He believes that physicians would be glad to render this service without pay.

Memorial Service for Dr. Black.—A memorial service for the late Dr. Green Vardiman Black, dean of the Northwestern University Dental School, who died August 31, was

held in the Hotel LaSalle, December 14, by the Chicago Dental Society. Addresses were made by President Harris of Northwestern University, who spoke of Dr. Black as the dean of the dental department of that institution; Dr. Fred B. Noyes, who paid tribute to the student, investigator and inventor; Dr. C. N. Johnson, who spoke on "The Teacher and Writer"; and Dr. Thomas L. Gilmer, the subject of whose address was "The Man and Friend."

INDIANA

Trachoma.—Fifty cases of trachoma have been found in Indianapolis, some of the cases among schoolchildren.

Personal.—Dr. Clarence H. Mead, health commissioner of Bluffton, is ill with diphtheria.——Dr. Andrew J. Gray, Young America, is reported to be seriously ill as the result of a cerebral hemorrhage.——Dr. T. Roy Cook, Bloomfield, who has been ill with general neuritis, is reported to be improving.

Physicians Running Drug Stores.—In one of the justice's courts in Indianapolis a physician was convicted of running a drug store without a license, because he had filled the prescriptions of another physician. This case was appealed from the justice's court to the county criminal court where the verdict was upheld.

Measles.—Under date of December 18 it was said there were 140 cases of measles in Indiana Harbor. A meeting of the health board with school physicians and inspectors was held to consider the epidemic. A circular was prepared by the health department giving instructions to the heads of families with regard to the prevention of the spread of the disease.

MONTANA

Personal.—Dr. Clem C. Seerley, Manhattan, is taking postgraduate work in New York City.——Dr. Alfred N. Smith, Glasgow, has been appointed physician of Valley County.——Dr. Daniel J. Donohue, Glendive, has moved to Butte.

New Society Organized.—The organization of the Southeast Montana Medical Society was perfected at Miles City, December 3: Dr. Wimon W. Andrus, Miles City, was elected president; Dr. Virgil P. Garst, Terry, vice president; Dr. John G. Randall, Missoula, secretary, and Dr. Sadie B. Lindeberg, treasurer, Miles City.

NEW YORK

Emergency Health Expenditures.—The attorney-general in an opinion rendered to the health officer of the port of New York says that he may, with the approval of the governor, not only expend the fees collected by him, but may employ any additional measures he deems necessary. It is stated in section 37 of the state finance law that the health officer must turn into the state treasury by the fifth of each month the fees received by him. This gives him in cases of immediate danger the power to use them in the protection of the public health.

Tuberculosis Patients and the Law.—The state law gives health departments power to enforce their mandates with reference to the care of tuberculous persons. Many afflicted with tuberculosis are not careful to comply with the measures necessary to prevent the spread of the disease to others. It has been necessary in some instances to enforce the regulations of health boards in this respect by application to the courts. Several such instances have occurred in Buffalo. Tuberculous persons who are refractory in this respect may even be sent to the penitentiary where special quarters are set aside for them.

Health Centers.—Buffalo has three health centers, the last established at the Municipal Hospital, 770 East Ferry Street. The two centers first established were very successful in their work. This led to the opening of a third center and others may possibly follow. The outstanding feature of the work at these centers is their cooperation with the various private welfare agencies. The scope of these health centers includes: prenatal work, child welfare—not only immediately after birth but until school age—supervision of midwives, prevention of blindness and conservation of vision, milk dispensaries, egg dispensaries, dental dispensaries, tuberculosis dispensaries and social service. This cooperation prevents waste of energy and the duplication of work; it will also save expense.

New York City

Eminent Chemist Dead.—A telegram has just been received announcing the death in New York City, on December 20, of Dr. Rudolph August Witthaus, aged 69, the eminent chemist and toxicologist, professor of chemistry and toxicology in the University Medical College, New York City, and Cornell University, and emeritus professor since 1911; the author of several standard works on chemistry, urinalysis and toxicology.

Building Fund for Women's Medical College.—At the meeting of the Woman's Guild of the New York Medical College and Hospital for Women it was announced that $25,000 has been pledged toward the $200,000 required for a new building for the college. The largest gift, $10,000, came from W. W. Cole, and Cornelia C. Brant, the dean of the college, gave $2,000. Among the subscribers are 104 women and 99 men.

NORTH DAKOTA

Obtains Position in Red Cross.—Dr. Thomas J. Strong, Williston, has received appointment as Red Cross director with the American Red Cross in Germany.

State Laboratory Charges Fees.—Dr. Leverett D. Bristol, University, director of the State Public Health Laboratory, announces that the State Board of Regents has authorized the charging of fees for all work which is not strictly public health work and which the laboratory is not called on to do by the law.

Health Survey of State.—Surg. Carroll Fox, U. S. P. H. S., has completed his health survey of North Dakota, and states in his preliminary report that the chief needs of North Dakota are a sanitary engineer who will devote his whole time to the work and whole-time health officers and correlation in public health service.

Smallpox.—At Grand Forks, December 2, it is said there were thirty-six cases of smallpox. The vaccination order had been generally obeyed by the schoolchildren. Attorney-General Linde has given an opinion that the regulations requiring vaccination may be enforced, although this is contrary to an opinion delivered by his predecessor. There were also many cases in East Grand Forks. The disease was mild and no deaths had occurred. The health board by resolution urged on the board of education that a rule requiring the vaccination of all schoolchildren be established.——In an effort to suppress an epidemic of smallpox at Bismarck, the school authorities have prohibited teachers to attend theaters and children to attend motion-picture shows and have made vaccination compulsory.——The physicians of Mandan are at hard work in an effort to prevent the spread of the disease.

Hospital Notes.—The new hospital at Fort Yates, Standing Rock Reservation, which has been erected at a cost of $26,000, is practically completed and will be opened early in January.——A site has been selected for the Crosby Hospital on the Herring farm adjoining the city. The building is to be 50 by 70 and two stories in height.——C. C. Marson, Cooperstown, has agreed to donate a half block within the city limits, providing a hospital is built thereon, and a quiet campaign is being carried on to secure funds for the construction of the building.

OHIO

Health Sunday.—Health Sunday was observed in Youngstown, November 28, when the pastors of twenty churches gave up their pulpits to physicians who delivered addresses on various phases of public health.

Conserving Vision.—Cincinnati is about ready to form its third class in the schools for the conservation of vision. During the previous two years 3,475 schoolchildren with defective vision were found, 1,179, or 51 per cent., of whom were provided with glasses up to June 20, 1915. Regulations for the admission of children to the special classes have been published.

New Faculty Appointments.—The following appointments have recently been made to the faculty of Western Reserve Medical School: Dr. Julius M. Rogoff of Vanderbilt University, Nashville, Tenn., instructor of experimental medicine; Dr. Cyrus H. Fiske, Harvard Medical School, Boston, associate in biochemistry; Dr. Roy W. Scott, formerly demonstrator in medicine in Western Reserve University, instructor in physiology.

Vaccination.—Notices have been posted at the mills of the Carnegie Steel Company at Youngstown requesting all

employees to submit to vaccination in accordance with the recommendation of the Youngstown Board of Health. The company will not compel the employees to be vaccinated, but they are strongly urged to submit to this measure, which will be carried out free of charge. The Youngstown Iron and Steel Company had previously made a similar request of the men, and it is believed that all other industrial concerns in the city will follow this plan.

Personal.—Dr. Frederick E. Dilley, instructor in surgery in the Union Medical College, Peking, Chih-li, China, has returned and will take postgraduate instruction in Cleveland until next August.——Dr. Alfred Irving Ludlow, professor of surgery and surgical pathology in the Seoul Medical College, Korea, will sail for the Orient, June 8.——Dr. George Niel Stewart, director of the H. K. Cushing Laboratory of Experimental Medicine at Western Reserve University, Cleveland, has returned from abroad.——Dr. Herbert E. Twitchell, Hamilton, has been appointed assistant surgeon at the National Military Home, Dayton.——Dr. Eli R. Crew, superintendent of the Miami Valley Hospital, Dayton, is ill and under treatment in the hospital.——Dr. Fred B. Larimore, New Philadelphia, is seriously ill in the Columbus Hospital as the result of a hemorrhage.

Cincinnati

Scholarship Donated.—Gifts of $600 each have been made by Henry Strauss, Casper H. Rowe, Adam A. Kramer and Albert Lackman for scholarships in the medical department of the Cincinnati University.

Return After Tour of Medical Colleges.—Dr. Christian R. Holmes and Profs. Martin H. Fischer and H. M. Knower of the University of Cincinnati and Architect Harvey Haniford have returned after two weeks' tour of inspection of medical colleges in the East, and during which they submitted plans for the new medical college to experts for their consideration and criticism.

Personal.—Dr. Samuel J. Holdberg has been appointed assistant clinical instructor of laryngology and otology in the medical department of the university.——Dr. Lewis Bader has resigned as receiving physician at the General Hospital and will take up Roentgen-ray work. He has been succeeded by Dr. Max Shaweker.——Dr. Earl A. Martin, Mount Vernon, has been appointed assistant to Dr. Harry Freudenberger of the Tuberculosis Sanatorium.——Dr. Eric A. Fennel has resigned as physician in charge of the City Infirmary and the two house of refuge farms.

OKLAHOMA

Free Antitoxin.—Dr. John W. Duke, Guthrie, state health commissioner, announced that free diphtheria antitoxin will be distributed in all deserving cases.

Research Department to Be Established.—Announcement was made, December 1, by the officials of St. Anthony's Hospital, Oklahoma, of the immediate establishment of a medical research laboratory to be in charge of Dr. Abraham Sophian, New York City, and of the building of an addition to the hospital to cost $150,000.

Personal.—Dr. I. H. Lamar, Texhoma, who has been ill with typhoid fever in Kansas City, has recovered and returned home.——Dr. Albert M. Chambers, McCurtain, was recently operated on for appendicitis.——Dr. Benjamin W. Ralston, Lindsay, is convalescent after a severe attack of septicemia.——Drs. Ross D. Long and George D. McLean, Oklahoma City, are on duty with the Allies in France.

New Organizations.—The Tulsa Academy of Medicine was organized October 28, and the following officers were elected: president, Dr. W. Forest Dutton; vice-president, Dr. Robert S. Wagner; and secretary-treasurer, Dr. Paul N. Atkins.——Physicians in the Henryetta District organized the Henryetta Hospital Association, November 27, electing Dr. Nathaniel N. Simpson, president, and Dr. C. N. Stevenson, secretary-treasurer. The purpose is to found and build a modern hospital. A favorable report was made at this meeting on the plans and finances.

PENNSYLVANIA

Personal.—Dr. Joseph D. Findley has been selected as health physician of Altoona, succeeding Dr. Jesse P. Seedenburg, removed from the city.——Dr. Frank Horning, Hellam, is reported to be ill at his home.

Addition to Sanatorium.—The Philadelphia Sanatorium for Consumptives at Eagleville is installing a completely equipped Roentgen-ray department for scientific study and research in pulmonary tuberculosis. Dr. Gilbert M. Neuberger has been appointed roentgenologist.

Philadelphia

Mütter Lecture Postponed.—Owing to illness in the family of Dr. Rudolph Matas, New Orleans, the Mütter lecture and reception scheduled for December 17 was postponed.

Physicians Motor Club House.—Negotiations have been completed for a club house and supply station for the Physicians' Motor Club of Philadelphia. This will be ready for occupancy and transaction of business very soon after Christmas.

Personal.—Dr. Charles B. Penrose, who was taken suddenly ill with pleurisy in Baltimore and removed to Johns Hopkins Hospital, has greatly improved and will return to his home in a few days.——Dr. Mary W. Griscom, who recently returned from a trip through the Far East, visiting medical women in isolated stations, was the guest of honor at a dinner given December 16, at the Hotel Adelphia, by a number of her associates.——Dr. Frank W. Swallow has been appointed assistant medical inspector in the bureau of health.——Dr. William Hewson has been appointed an assistant school medical inspector.——Dr. Wilmer Krusen, the new director of health and charities, was the guest of honor at a dinner given at the home of Dr. Frank C. Hammond, December 9.

Duhring Annex Dedicated.—The Duhring Memorial Building, recently erected annex to the library of the University of Pennsylvania, was dedicated in the afternoon of December 13. A memorial tablet to the donor, Dr. Louis Adolphus Duhring, class of 1867, medical department, clinical professor, professor and finally emeritus professor, was unveiled at the entrance of the annex. Brief addresses were made by Maurice Jastrow and Joseph T. Rosengartner. Provost Edgar F. Smith accepted the building on behalf of the university. The new wing extends across the south end of the library, is of red terra cotta and brick work, the design being in keeping with the old structure. This addition is a emmorial to the late Dr. Duhring, who left more than a million dollars to the university.

TENNESSEE

Personal.—Dr. James W. McClaran, Jackson, has accepted a position in a war hospital in Paris.——Dr. Henry Berlin, Chattanooga, is reported to be seriously ill at his home.

Minnesota Surgeon in Chattanooga.—Dr. J. Minor Blackford, Rochester, Minn., delivered an address on December 10 before the physicians of Chattanooga on "Newer Cardiac Pathology and Diagnosis," illustrated by moving pictures.

Physician Wins Suit.—In the suit brought by the father of Hyram Henderson, Potts Camp, Miss., against Dr. Frank D. Smythe, Memphis, in which damages for $20,000 were claimed on account of negligence in performing a surgical operation, the jury rendered a verdict December 3, in favor of Dr. Smythe.

State Board Officers Reelected.—At the annual meeting of the State Board of Health held in Nashville, November 6, the following officers were reelected: Dr. Rufus E. Fort, Nashville, president; Dr. Walter J. Miller, Johnson City, vice president, and Dr. Reese Q. Lillard, Lebanon, secretary and executive officer.

New Officers for Middle Tennessee Association.—The forty-third semiannual meeting of the Middle Tennessee Association was held at Sparta, November 18 and 19: Dr. Roy W. Billington, Nashville, was elected president; Dr. W. Scott Farmer, Cookeville, vice president, and Dr. John Witherspoon, Nashville, secretary-treasurer. Lewisburg was selected as the next place of meeting.

Sanatorium at State Prison Opened.—The new modern tuberculosis hospital connected with the State Prison, Nashville, which has been erected at a cost of $40,000, was opened December 4 and 125 infected state prisoners were installed in the new institution. Hereafter, all prisoners sent to the penitentiary will be carefully examined for tuberculosis at the time of their admission.

Preventable Blindness.—The campaign against preventable blindness is being pushed vigorously by organizations in Nashville. A pamphlet has been prepared giving the state law on the subject, outlining the methods of preventing blindness in infants, and laying emphasis on the importance of the subject. The pamphlet has been endorsed by the State Board of Health and the Nashville health authorities.

TEXAS

Drug Law Violations.—In the federal court at Fort Worth, December 6, fourteen persons were sent to jail for violation of the antinarcotic law.

North Texas Physicians Hold Meeting.—The North Texas Medical Association held its annual meeting in Fort Worth, December 7 and 8, and adjourned to meet in Greenville in June. Dr. Charles R. Johnson, Gainsville, was elected president; Dr. Claude O. Harper, Fort Worth, vice president; Dr. H. Leslie Moore, Dallas, secretary (reelected for the thirty-second term), and Dr. John H. McLean, Fort Worth, treasurer.

Diphtheria.—In October diphtheria was reported from fifty-three of the 252 counties in the state, the largest number of cases in any one county being forty-one. There was a total of 554 cases. Under contract made by the State Board of Health, antitoxin approved by the United States Public Health Service costs patients $4 per 10,000 units as against $12.50, the price formerly charged. It has been concluded that if an average of 15,000 units was used in each case of diphtheria, at the new price there would be a saving of over $7,000 to the people of the state. Distributing stations have been established in every county of the state, although it is believed the people are not all aware of this arrangement for distributing antitoxin.

CANADA

Word from Saloniki.—The Toronto University Base Hospital is located 5 miles north of Saloniki on the road to Monastir. Directly in front of their camp is the railroad to Nish. At the present time there are about 500 patients, very few wounded soldiers, but mostly cases of typhoid dysentery and influenza.

Germany Refuses to Liberate Hon. Dr. Beland.—The German government has refused to liberate the Hon. Dr. Beland, former postmaster-general of Canada, who was captured at the fall of Antwerp. They are willing, however, to exchange him for a lieutenant of the German Army now in the London Tower under sentence of death for espionage.

Canadian Appointments.—The following Canadian physicians have been gazetted lieutenants, R. A. M. C.: Drs. C. E. Wilson, H. C. Sutton, H. B. Moyle, H. P. Rogers, A. W. Nixon and H. B. Stacpoole, all of the Canadian Army Medical Corps.——Drs. James Donald, M. MacAdam and Norman Ferguson have been appointed captains in the army service corps.——Major J. T. Clarke, M.D., formerly a practitioner in Toronto, has been promoted to lieutenant-colonel and has been placed in charge of No. 2 Stationary Hospital, Boulogne, France.

Toronto Convalescent Home Staff.—For the returned soldiers in Toronto the medical staff of the Convalescent Home is being chosen by Lieut.-Cols. Herbert A. Bruce and Harry B. Anderson, who will be chief surgeon and physician, respectively. The following are the appointments so far named: Drs. Herbert J. Hamilton, Goldwin Howland, Jabez H. Elliott, Brefney O'Reilly, Robert W. Mann, Harold Tovell, William J. McCollum, D. J. Gibb Wishhart, Colin Campbell, George H. Burnham, Newbold Jones, John A. Oille, Arthur Wright, Charles B. Shuttleworth, A. Muirhead, Charles Temple and Albert E. Webster, M.D., D.D.S.

University Looks for Government Aid.—A deputation from Queen's University, Kingston, Ont., recently waited on the premier of Ontario and the provincial treasurer to ascertain the attitude of the government toward the future of that institution. Three years ago Queen's severed its connection with the Presbyterian Church in Canada, and following that the Mining School agreed to affiliate with the University. The Ontario government has been giving Queen's an annual grant of $70,000 for the mining and medical branches. On account of war conditions Queen's will have a deficit for the current year of $30,000, the large number of enlistments from the student body having brought about a decreased attendance and a consequent decrease in the fees received. The government has promised to consider the matter.

GENERAL

Correction.—In the article by Woodyatt, Wilder and Sansum, THE JOURNAL, December 11, p. 2068—the last sentence of the first paragraph, second column, p. 2069, should read—"But if the glucose is given at a rate faster than 2 gm. per kilogram and hour, 50 per cent. of all glucose injected appears in the urine, once constant conditions have been secured." In the third paragraph the figures 3.6 gm. should be 2.7 gm.

Roentgenologists Unite.—About seventy-five roentgenologists from Illinois, Indiana, Iowa, Missouri and Kentucky met in Chicago, December 15 and 16, and organized the Western Roentgen Society, electing the following officers: president, Dr. Fred S. O'Hara, Springfield, Ill.; vice presidents, Drs. Miles B. Titterington, St. Louis, and Noble M. Eberhart, Chicago; secretary, Dr. Thomas A. Burcham, Des Moines; and treasurer, Howard Raper, D.D.S., Indianapolis. The next meeting will be held in Chicago, June 15 and 16, 1916.

Compensation for Federal Employees.—The American Association for Labor Legislation announces that the Kern-McGillicuddy Bill to provide just compensation for federal employees will be introduced into the new congress at an early day. This bill, which was reported favorably by the judiciary committee of the last congress, and has been endorsed by the Federal Bureau of Labor Statistics, American Federation of Labor and other bodies, was drafted to supersede the law of 1908. Nearly three quarters of the half million employees of the United States are not entitled to any compensation whatever for injuries and moreover, no injured workman can sue the national government for liability. In the present year, eight states have adopted the workman's compensation bill far in advance of the existing law for federal employees while five of the thirty-three states which have workman's compensation law have adopted liberal and progressive amendments.

Examination for Philippine Service.—The United States Civil Service Commission announced that open competitive examinations will be held on January 8, for the positions of bacteriologist and pathologist (male), with a salary of $2,000 to $2,500 a year, and for assistant surgeon (male), with a salary of $1,800 a year. The competitors will not be assembled for examination, but will be rated on education, experience and publication or thesis. Applicants must be graduates in medicine and must have had special training in bacteriology, must be between 21 and 40 years of age, and must have executed the prescribed medical certificate. Persons who meet the requirements and desire the examination, should apply for Form B.I.A. 2 and 2118 stating the title of the examination for which the forms are desired, and these applications should be sent to the United States Civil Service Commission at Washington, or to the secretary of any local United States Civil Service Board. They must be filed prior to the hour of closing business on January 18.

Deaths Abroad.—Kenneth William Millican, M.R.C.S., England, 1879; L.R.C.P., Edinburgh, 1880; for two years a member of the editorial staff of THE JOURNAL; died at his home in West Kensington, London, November 28, aged 62. After graduating in medicine, Dr. Millican was for several years an officer of the Royal Army Medical Corps in India and Africa, and then came to this country. While here he acted as associate editor of the *New York Medical Journal*, under the late Dr. Frank P. Foster; editor of the *St. Louis Medical Review*, and later became associated with THE JOURNAL. In 1909 he returned to St. Louis for a short time as editor of the *Bulletin of the Municipal Commission on Tuberculosis*, and then returned to England as a member of the editorial staff of the *Lancet*. Dr. Millican's society affiliations included Fellowship in the American Medical Association and membership in the British Medical Association, Missouri State Medical Association and St. Louis Medical Society, of which he was once president. Dr. Millican was a gentleman of charming personality, a scientist of high rank and a writer of high literary ability.

Death Rate in Registration Area in 1914.—According to a bulletin issued by the Bureau of the Census, the total number of deaths recorded in the registration area in 1914 was 898,059, corresponding to a death rate of 13.6 per thousand population. This rate is said to be the lowest on record, the next lowest being for the year 1912, when the rate was 13.9. This has added significance by reason of the fact that the number of states in the registration area has increased since 1912, the number now being twenty-five, comprising 66.8 per cent. of the total estimated population in the United States in 1914. The death rate for 1914 is said to be 16 per cent. lower than the average for the five year period of 1901-1905. This means that in 1914 there were only 10 deaths, where ten years earlier there were 11 deaths. Decreases in the death rate in the number of states of the registration area in 1914 as compared with 1901-1905 period are as follows: Rhode Island, 17.4 per cent.; New York, 14; New Jersey, 11.8; Massachusetts, 11.4; Vermont, 7.4; Connecticut, 3.8; Indiana, 2.3; Maine, 1.9, and New Hampshire, 1.8. Michigan showed a slight increase, 0.8 per cent. It is shown that in

cities of 100,000 or over the tendency is toward a still greater reduction. In comparing the five year period 1901-1905 with 1914, the following reductions were shown in cities: Jersey City, 28.5 per cent.; New York, 25.8; San Francisco, 23.6; Denver, 23.3; Newark, N. J., 22.5; Los Angeles, 21.3; Pittsburgh, 21.9; Atlanta, Ga., 21.8; Lowell, Mass., 21.3; and Paterson, N. J., 20.1. The caution is given that these figures are crude rates and that inferences regarding the relative health advantages of different states should not be drawn without more thorough investigation.

Report of the Surgeon-General of the U. S. P. H. S.—The advance summary of the annual report of the surgeon-general shows that the organization under the broadened functions assigned to it by the law of 1912 has made possible the largest amount of work in its history. Among the notable features of this work for 1915 enumerated in the summary are: the conclusion, after seven years of investigation, that pellagra is a deprivation disease; the establishment of a new quarantine station at Galveston, and the transference of the station at Boston to the Public Health Service; eradication of plague from New Orleans, and the establishing of extensive rat-proofing and other antiplague measures; great reduction in the incidence of malaria where surveys were conducted, and the establishment in this connection of the fact that malaria is carried over the winter by persons infected with the disease rather than by hibernating mosquitoes; important knowledge gained from the study of occupational diseases and tuberculosis among industrial workers, and relating to the migration of persons suffering from tuberculosis; improvement in the powers and duties of health boards in five states, on the recommendations of the Public Health Service; investigation of the pollution of streams and the examination of shellfish; important studies of trachoma in the Appalachian Mountains, where over 12,000 cases were treated; rural sanitation work in six different states, resulting in the reduction of typhoid and other communicable diseases; and the establishment at Chicago, Seattle and other railway centers of public health laboratories for the prevention of the interstate spread of disease. On account of the extension of relief benefits to the newly organized Coast Guard and the physical examination of seamen applying for the rating of "able seamen," the service asks for an increased force to take care of this additional work. An additional building for the Hygienic Laboratory and the establishment of a national leprosarium are also recommended in the report.

Bequests and Donations.—The following bequests and donations have recently been announced:

Harvard College, $75,000, the remainder of the bequest of Morrill Wyman to establish the Morrill Wyman Research Fund, the income to be applied to investigation by Harvard Medical School, into the origin, results, prevention and treatment of disease.

Harvard Unit in France, $4,000; American Ambulance Field Service fund, $4,000, and New England-Belgium relief fund, $3,537.39, being the amount collected in the stadium at the Harvard-Yale football game.

Children's Hospital, Brookline, Mass., $3,000; Boston Floating Hospital, $2,000, and Angell Memorial Animal Hospital, $2,000 by the will of Edward Frieze Cohasset, Mass.

Americus, Ga., Hospital Association, $2,500 by Mr. and Mrs. Frank Lanier, Americus, in memory of their son who died November 25.

James Walker Memorial Hospital, Wilmington, N. C., an annex for the treatment of children and nursing mothers, erected by Mr. and Mrs. James Sprunt, Wilmington, as a memorial to their deceased daughter, to cost $30,000.

School of Medicine, of the University of Kansas, Rosedale, the balance of the estate of Dr. Joseph Porter, Paola, appraised at from $27,000 to $37,000, the income only from this fund to be used, and of the income, $300 is to be used for a scholarship, the remainder to be used as thought advisable by the dean.

University of Kansas, Rosedale, donations of three acres of land to be added to the campus, from the Bell estate, Dr. Marshall A. Barber, Rosedale, and Mr. H. L. Rose.

United Hebrew Charities and Mount Sinai Hospital, New York City, each $2,500; Montefiore Home, $2,000; Home for Aged and Infirm Hebrews, Hebrew Infirmary and German Hospital, each $1,500 by the will of Bernhard Ulmann.

Eaglesville (Pa.) Sanatorium for Consumptives, about $4,000, the proceeds of a card party and dance given December 8, under the auspices of the Ladies' Auxiliary of that institution.

Abbington (Pa.) Memorial Hospital, a nurses' home to cost $50,000, on property adjoining the hospital, donated by George W. Elkin, Sr., in memory of his wife.

University of Pennsylvania for the use of its hospital, two-ninths of the residue of the estate of William B. Rawle, after the death of Mrs. Rawle; Children's Hospital, Philadelphia, establishment of a free bed to be known as the Charles Wallace Brocke, Jr., free bed, by the will of the mother of Mr. Rawle on the death of his wife.

Children's Aid Society, Country Week Association, Society for Protection of Children from Cruelty, and Sanatorium Association for Children, $4,000 each, by the will of Henry A. Rogers.

Children's Hospital, Philadelphia, a bequest of $10,000 for the endowment of a free bed in memory of her son George, by the will of Emily M. Price.

Women's Homeopathic Hospital, $5,000, by the will of Mary E. Harbeson.

American Oncologic Hospital and Kensington Dispensary, each $1,000, by the will of Maggie Green.

LONDON LETTER

London, Nov. 26, 1915.

The War

THE TYPHOID GROUP OF DISEASES

The immense experience of the war is extending our knowledge of disease in several directions. In previous letters it has been shown that, thanks to the excellence of medical arrangements, and to inoculation in particular, the incidence of typhoid fever among the troops has been very low. The fact has come to light that a good many of the cases which clinically appeared to be typhoid fever were examples of paratyphoid fever. Thus, in a recent discussion at the Royal Society of Medicine, Sir Bertrand Dawson stated that of 1,636 cases first regarded as typhoid fever, 910 proved to be paratyphoid. Among them were many of the form of paratyphoid A which is little known in this country though common in India; the form paratyphoid B has been recognized in England for some time. Observations in regard to inoculation tend to confirm the specificity of the several pathogenic micro-organisms responsible for the various forms of infectious disease. Thus it has been shown that inoculation against typhoid infection does not confer immunity to paratyphoid, and that inoculation against the one infection does not increase susceptibility to the other. It would seem that safety can be secured only by a number of inoculations, each directed to a specific end. However, quite satisfactory results follow the practice of simultaneous mixed inoculation. Thus Professor Dreyer reports that the injection of a vaccine containing in certain proportions the typhoid bacillus, paratyphoid bacillus A and paratyphoid bacillus B is followed in some cases by protection against all the three infections and in other cases by protection against two of them, and this without any greater immediate disturbance than is common in the ordinary antityphoid inoculation. Professor Castellani has gone further and has used what he calls a tetravaccine, which aims at protection not only against the three infections mentioned but also against cholera. His experience in Serbia includes 50,000 men, and he reports absence of immediate ill effects and the practical absence from the inoculated troops of the diseases in question.

THE CARE OF THE BLIND SOLDIER

Soon after the outbreak of the war, the need was recognized of an institution for those sad cases of loss of the sight of both eyes from the injuries of warfare. The Hostel of St. Dunstan's, Regent's Park, London, was established, and is being maintained by the National Institute for the Blind, the British Red Cross, and the Order of St. John of Jerusalem. The Hostel, which was given by Mr. Otto Kahn, stands in about 15 acres of ground. It includes a portion of the Regent's Park lake, which affords facilities for rowing—a pastime keenly appreciated by the blind inmates. The men come from the various military hospitals, and are afforded the opportunity of learning a trade by which they may earn a livelihood. The occupations taught include carpentry, boot repairing, mat and basket making, massage and telephony. An interesting adjunct to the institution is the model farm, under the care of Captain Webber, a blind expert. Here the men are taught market gardening, bee keeping and poultry farming; and by clever devices it is possible for the patients to carry on the work with success. After a short period of training they can drive birds from one pen to another, catch any particular fowl, and collect eggs. Arrangements have also been made for attendance at a neighboring public bath on certain days. The exercise of swimming is much enjoyed by the men, and some of those who were non-swimmers are rapidly becoming experts in the art. The Council of the National Institute for the Blind has placed at the disposal of the committee its seaside home at Brighton, where men can be sent to recuperate after discharge from hospital and previous to their taking up their training.

THE RECRUITING OF MEDICAL STUDENTS

A scheme of recruiting the whole country for the army has been adopted. Fit men are given the option of joining the army at once or being attested and placed in one of forty-six groups of all those aged from 18 to 40 years. There are twenty-three groups for single men (each year of age constitutes a separate group) and twenty-three similar groups for married men. The first group consists of single men aged 18, the forty-sixth group of married men aged 40. It is proposed to call the men up in the numerical order of the groups, except that men of 18 will not be called up for service until they have attained the age of 19. The special case of the medical student has given rise to a good deal of

discussion. As stated in a previous letter, the War Office decided that in consequence of the great shortage of physicians, fourth and fifth year students should proceed with their course and qualify as soon as possible so as to be able to enter the army as surgeons. On the other hand, students in the first, second and third years should, if physically fit, join the army as combatants. Exception has been taken to this rule because of the shortage of physicians which it will create in future years by withdrawing so many students from their studies. But the authorities pointed out that the need of the army must be paramount at the present moment, and that medical students who are generally men of good physique and full of spirit and courage make admirable combatant officers. However, some extension of exemption has been granted in the latest announcement from the War Office. Students who at or before the close of the present winter session will be qualified for entry to one of the examinations for the third year students in medicine, and duly enter for the examination for which they are studying, will not be attested until after its conclusion, and if they are successful will be included in the class of fourth year men.

THE BIRTH RATE AND THE WAR

At the Royal Sanitary Institute, Dr. Louis C. Parkes, a well-known health officer and authority on hygiene, read a paper on the national and social aspect of the lowered birth rate. He said the birth rates of nearly all the European nations had been steadily decreasing during the past thirty years. He estimated the total destruction of life in Europe in two years of war at nearly 20,000,000 persons. But in past ages of the world's history, evolution of higher types in animal and vegetable life had resulted from cataclysmic changes, and great destruction by plague, pestilence and famine had led to an advance in civilization. So it was possible that Armageddon might be of ultimate benefit to humanity. The figures for England and Wales for the past forty years showed that on the whole the birth rate had been falling faster than the death rate, and the mean rate of increase, except for the first few years of the present century, showed a downward tendency. There was foundation for the belief that the lowering of the birth rate had been specially marked among the upper, the middle and the superior working classes. Tables giving mean birth rates among other nations for the years 1910-1912 showed generally that nations largely agricultural had the highest birth rates, while in the more highly industrialized countries the birth rates were lower. With the exception of Bulgaria, with a decided increase in the rate of 3.6, and of Ireland and Roumania, with very slight increases, most of the nations which furnished statistics showed lowered birth rates in the course of the last quarter of a century. After the war a government commission should be appointed to make exhaustive inquiry into the whole question with a view to taking measures of social and economic amelioration. With a happy combination of circumstances the country should start a new life, and the replenishment of its young life on a sufficiently ample scale might be anticipated.

Tuberculosis in the Boot and Shoe Industry

There is an unusually high incidence of tuberculosis in the boot and shoe industry. The means of dealing with this has been investigated by the Medical Research Committee appointed under the national insurance act for such purposes. The high mortality is attributed to several factors, among these being the sedentary nature of the employment and the attitude adopted, the presence of infected workers who are by circumstances favorably placed for disseminating bacilli among their neighbors, the lack of sufficient daylight and adequate ventilation, and the presence of infected dust. The economic as well as hygienic advantage of so-called play intervals is insisted on. A quarter of an hour interval at 11 a. m. and again at 4 p. m. is suggested, and opportunity for Swedish drill or for games. It has been shown that more and better work is done with than without such intervals. The importance of ventilation and keeping the factories adequately cool is also insisted on.

BERLIN LETTER

BERLIN, Nov. 9, 1915.

Birth Rate and Nurslings' Mortality in the Large German Cities During the War Period

The records of the imperial health bureaus of twenty-six German cities having more than 200,000 inhabitants show, as was to be expected, that with the beginning of the tenth month of the war the number of living new born has diminished considerably. For instance, in Berlin during the month of April the birth rate was 17 against 79 in the same month of the previous year. Exactly nine months after the declaration of war during the first week of May, 99 fewer children were born in Berlin than during the previous year. In the second week 138 and in the last week of May 198 fewer children were born and during the second week of June the decrease was 244. This is the height of the growth of the lowering of the birth rate. The diminution thereafter was usually below 200. In the other large cities there was in part an increase during the month of April but beginning with May there was a considerable diminution. The one exception is the city of Essen but even here the increase in the number of births was due to an increase in population. In Cologne the diminution was the least but here, as in Essen, the death rate during the first year of life was increased. Elsewhere this death rate was diminished. One must not construe, however, that there was a general falling off in the death rate of infants because, arriving at such a conclusion, one must estimate how many deaths occur among the nurslings born during that time.

Value of Prophylactic Immunization in Typhoid

During the Franco-Prussian war there were 74,205 cases of typhoid, from 8 to 9 per cent. of the whole number of soldiers. There were 8,904 deaths, or about 1 per cent., of the total strength of the army. More than one half, 60 per cent., of the total loss for all the troops was caused by typhoid. The observations made during the prophylactic immunization of the troops in Southwest Africa showed that among protected soldiers there were fewer and less severe cases of typhoid than among the unvaccinated soldiers. The death rate among the vaccinated was 4 per cent., among the unvaccinated 11.1 per cent. Therefore vaccination against typhoid is not an absolute protection against the disease but typhoid in a vaccinated person runs a very mild and much more favorable course. In those vaccinated more than once the course of the disease was even more favorable. Positive conclusions as to the value of such vaccination in the present war cannot as yet be drawn but the numerous observations that have been made enable one to express an opinion as to the value of this prophylactic immunization. Goldscheider and Koner have reported that in addition to vaccination prophylactic sanitary measures were prescribed and to these a large measure of the success obtained must be ascribed. The vaccination therefore was only an operating factor in the reduction of the number of cases of typhoid and the death rate from typhoid. The course of the fever was much less severe among the vaccinated than among the unvaccinated. The temperature was lower but the duration of the fever was not appreciably shortened. There is almost a complete absence of headache, restlessness and delirium and convalescence is rather rapid. Fewer complications are met with among the vaccinated; especially is this true of the disastrous effects on the heart muscle, and when complications did occur they were much less severe. Among the soldiers vaccinated twice the course of the disease was even more favorable. Among the vaccinated the death rate was 6.9 per cent., among the unvaccinated the death rate was 12 per cent. One must not forget that the general hygienic prophylaxis which can be carried out during war time is not comparable with the prophylaxis in time of peace and therefore the prophylactic immunization against typhoid undoubtedly is of much greater value in peace than in war. However, we must admit that such immunization is of very great value especially in war times.

Marriages

CHARLES JOHN HUFNAGEL, M.D., to Miss Lucina Kirst, both of Cannelton, Ind., November 25.

PHILIP NEWTON, M.D., Washington, D. C., to Princess Shahofskaya of Petrograd, Russia, recently.

WALTER S. CLACK, M.D., to Miss Elizabeth Haley, both of Rockwood, Tenn., December 8.

CLARA PAULINE SEIPPEL, M.D., to Robert A. Widdowson, both of Chicago, in Minneapolis, December 11.

FRANK MURRAY SCHEELE, M.D., Waukesha, Wis., to Miss Emma Edmonds of Wauwatosa, Wis., December 1.

ALLEN WHEELER HOLMES, M.D., Dansville, N. Y., to Miss Clara Lillian Merrill of Hamilton, Mass., December 7.

MARGARET CARTWRIGHT, M.D., to Joel B. Good, both of Albuquerque, N. M., November 30.

F. STUART GRAVES, M.D., to Miss Louise Brown, both of Louisville, Ky., December 11.

Deaths

George Peaslee Shears, M.D. New York University, New York City, 1886; aged 53; a member of the Medical Society of the State of New York; clinical professor of obstetrics in the New York Polyclinic Medical School; chairman of the board of directors of the City Hospital, Blackwell's Island; attending obstetrician to the City, Misericordia and New York Polyclinic hospitals; died at his home in New York City, December 12, from cerebral hemorrhage.

Edward H. Thrailkill, M.D. Kansas City Medical College, Kansas City, Mo., 1899; aged 52; a Fellow of the American Medical Association; professor of rectal surgery in the University of Kansas; rectal surgeon to St. Joseph's and the Swedish hospitals, Kansas City; proprietor and manager of Thrailkill's Sanitarium for Diseases of the Rectum, Kansas City; died at his home in Kansas City, December 7, from the effects of an overdose of chloroform.

Frank Joseph Sykora, M.D. Chicago College of Medicine and Surgery, 1909; aged 38; formerly a Fellow of the American Medical Association; a member of the Minnesota State Medical Association and well-known as a surgeon of Brainerd, Minn.; a director of the Brainerd City Bank; died in St. Joseph's Hospital, St. Paul, November 17, from disease of the intestines for which three operations had been performed.

Erastus Perry Swasey, M.D. College of Physicians and Surgeons in the City of New York, 1869; aged 68; a Fellow of the American Medical Association and a well-known practitioner of New Britain, Conn.; who had been ill for a long time with disease of the heart and kidney; died at his home in New Britain, November 13, from cerebral hemorrhage.

James Irving Cawley, M.D. University of Pennsylvania, Philadelphia, 1877; aged 62; formerly a Fellow of the American Medical Association; a member of the Medical Society of the State of Pennsylvania; register of wills of Bucks County, Pa., and postmaster of Springtown where he had practiced for thirty-six years; died at his home December 10.

Michael M. Leahy, M.D. University of Glasgow, Scotland, 1857; University of Dublin, Ireland, 1862; Jefferson Medical College, 1883; aged 75; a Fellow of the American Medical Association; for many years a practitioner of Chicago, but for the last twenty years a resident of Montana; died at his home in Anaconda, Mont., December 15.

George K. Binkley, M.D. University of Pennsylvania, Philadelphia, 1873; aged 69; a Fellow of the American Medical Association; president of the Schuylkill County (Pa.) Medical Society; a veteran of the Civil War and a well-known practitioner and druggist of Orwigsburg, Pa.; died at his home in that place, December 4.

William Brewster Millwee, M.D. Castleton (Vt.) Medical College, 1848; aged 89; one of the oldest practitioners of Greenwood County, S. C.; first president of the Greenwood Oil Mill and vice president of the Bank of Greenwood; once mayor of Williamston; died at his home in Greenwood, December 1.

Benjamin H. Perce, M.D. Medical College of Indiana, Indianapolis, 1873; aged 77; a member of the Indiana State Medical Association and for two terms president of the Madison County Medical Society; a veteran of the Civil War; died at his home in Anderson, Ind., December 3, from nephritis.

Lewis Frey, M.D. University of Pennsylvania, Philadelphia, 1888; aged 52; formerly a Fellow of the American Medical Association; visiting physician to the State Hospital and the Consumptive Hospital, Scranton, Pa.; died suddenly at his home in Scranton, December 6, from angina pectoris.

C. Robert Martin, M.D. Miami Medical College, Cincinnati, 1866; aged 73; one of the oldest practitioners and druggists of Henry County, Ky., and one of the directors of the Deposit Bank of Sulphur, Ky.; died at his home in that place, December 9, from cerebral hemorrhage.

Ira Dean Payne, M.D. University of Iowa, Iowa City, 1880; Bellevue Hospital Medical College, 1886; aged 63; who after many years of practice in Linton, Iowa, retired five years ago and moved to Des Moines; died at his home in that city, September 7, from heart disease.

James E. Gauline (license, Maryland), for more than twenty-two years connected with the Home Friendless Society, Waverly, Baltimore; died at his home in that place, December 3, from cerebral hemorrhage.

James Garrett Linthicum, M.D. University of Maryland, Baltimore, 1859; aged 81; formerly professor of the practice of medicine in Baltimore University; a member of the Baltimore city council for four terms; died at his home in West Baltimore, December 7, from pneumonia.

Jesse Lincoln Melton, M.D. Hospital College of Medicine, Louisville, 1902; aged 55; formerly a member of the Kentucky State Medical Association, and until a year ago a practitioner of Shelbyville, Ky.; died at his home in Louisville, December 10, from typhoid fever.

Rhys Williams, M.D. Western Pennsylvania Medical College, Pittsburgh, 1894; aged 46; of Federal, Pa.; for twenty years a practitioner of the Bridgeville District and director of the Bridgeville Trust Company; died at his home in Federal, about December 11.

John A. Kirkland, M.D. Jefferson Medical College, 1855; aged 59; a Fellow of the American Medical Association; for many years a member of the school board of Cambridge, Ill., and a well-known ornithologist; died at his home in Cambridge, December 10.

Henry Manning Fish, M.D. Hahnemann Medical College, Chicago, 1900; aged 62; a Fellow of the American Medical Association and American Academy of Ophthalmology and Oto-Laryngology; a well-known specialist; died at his home in Chicago, December 11, from pneumonia.

Ellis Henry Bishop, M.D. Bennett Medical College, Chicago, 1905; aged 43; a Fellow of the American Medical Association; died at his home in Neponset, Ill., December 5, from an overdose of medicine taken for the relief of acute gastritis.

Carl Martinus Nielsen, M.D. University of Copenhagen, Denmark, 1885; Bennett Medical College, Chicago, 1898; aged 59; president of the Scandinavian-American Medical Society, Chicago; died at his home in that city, December 14.

Lloyd McDonald Burgess, M.D. Marion-Sims Medical College, St. Louis, 1893; aged 44; a Fellow of the American Medical Association; died at his home in Delta, Colo., September 5, six months after an operation for cholecystitis.

John W. Davis, M.D. Georgetown University, Washington, D. C., 1860; aged 78; a veteran of the Civil War; and a resident of Lansing, Iowa, for more than fifty years; died at his home in Lansing, December 6, from heart disease.

John Jackson Esmond, M.D. University of Toronto, 1877; aged 63; for several years a practitioner and postmaster of Tracy, Mo., but for nearly twenty years a practitioner of Kansas City, Mo.; died at his home in that city, December 8.

P. Watt Cate (license, Tennessee, 1889), aged 61; for thirty-two years a practitioner of Charleston, Tenn., but who made his home for two years with his daughter at Solano, N. M.; died at his home near Charleston, December 10.

Lomax Anderson, M.D. University of Alabama, Mobile, 1879; aged 69; a Confederate veteran and an active practitioner of Jackson, Miss., until his retirement in 1908; died at his home in that city, December 9, from nephritis.

Jacob B. Lewis, M.D. Eclectic Medical Institute, Cincinnati, 1893; aged 44; formerly of Boise, Idaho; and for four years physician of Ada County; died on his stock ranch near Meridian, Idaho, December 5, from pneumonia.

Jeremiah Elwood Sayre, M.D. Jefferson Medical College, 1883; aged 63; for twenty-five years a member of the board of education of Red Bank, N. J.; died at his home in that place, December 11, from cerebral hemorrhage.

Wiley M. Baird, M.D. University of Nashville, Tenn., 1861; aged 75; a Confederate veteran and for one term state senator from the Jackson County District, Ark.; died at his home in Bentonville, Ark., December 4.

George W. Haislip, M.D. Jefferson Medical College, 1882; aged 57; a member of the Medical Society of Virginia and a well-known practitioner of Lorton, Va.; died in the Sibley Hospital, Washington, D. C., December 5.

Richard James Sadlier Wheeler, M.D. L.R.C.P., L.R.C.S., Edinburgh, 1884; M.D., University of Edinburgh, 1894; aged 53; of Birtle, Man.; died in the Winnipeg General Hospital, September 17, from cerebral hemorrhage.

Joseph Etienne Gendron, M.D. Dartmouth Medical School, Hanover, N. H., 1871; aged 72; of Worcester, Mass.; died in St. Vincent's Hospital in that city, October 5, from intestinal obstruction.

Samuel C. Corbett, M.D. Victoria University, Cobourg, Ont., 1867; aged 70; a resident of Winnipeg, Manitoba, from 1882 until a short time ago; died at Vancouver, B. C., September 18.

Thomas Miller, M.D. Howard University, Washington, D. C., 1884; aged 58; a member of the Medical Society of the District of Columbia; lecturer on anatomy and diseases of children in his alma mater; died at his home in Washington, November 30.

William Lewis Suesholtz, M.D. Long Island College Hospital, Brooklyn, 1907; aged 43; a member of the Medical Society of the State of New York; died at his home in Brooklyn, November 26, from the effects of an overdose of acetanilid.

Frank D. Wheeler, M.D. Detroit Medical College, 1880; aged 60; a Fellow of the American Medical Association and prominently identified with the medical work of Detroit for more than thirty years; died at his home in Detroit, November 27.

Laura J. Ross Wolcott, M.D. Women's Medical College of Pennsylvania, Philadelphia, 1856; aged 82; said to have been the third woman in the United States to receive a degree in medicine; died at her home in Chicago, December 8.

Francis Coffin Martin, M.D. Harvard Medical School, 1883; aged 57; formerly a member of the Massachusetts Medical Society and a Fellow of the American Academy of Medicine; died at his home in Roxbury, Boston, December 3.

Freeman Hardin Hornibrook, M.D. College of Physicians and Surgeons, Chicago, 1902; aged 37; a member of the Iowa State Medical Society; was found dead at his home in Cherokee, Iowa, November 30, from cerebral hemorrhage.

Patrick Henry Bumster, M.D. New York University, New York City, 1893; aged 56; visiting physician to St. John's Hospital, Long Island City, N. Y.; died at his home in Long Island City, December 1, from hemorrhage of the stomach.

Patrick J. Marren, M.D. Medico-Chirurgical College of Philadelphia, 1896; aged 43; a member of the Medical Society of the State of Pennsylvania; died at his home in Bellevue, Pittsburgh, November 28, from pneumonia.

William E. Scriber, M.D. Michigan College of Medicine, Detroit, 1883; aged 46; a member of the Michigan State Medical Society; died at his home in Detroit, December 3, from septicemia following a carbuncle of the neck.

John H. Ashcraft, M.D. Jefferson Medical College, 1855; aged 82; an honorary member of the Gloucester County, N. J., Medical Society; died at his home in Mullica Hill, N. J., September 26, from carcinoma of the back.

Louis Lee Abbott, M.D. Tulane University, New Orleans, 1898; aged 52; a member of the Louisiana State Medical Association; a practitioner and druggist of New Orleans; died at his home in that city, November 30.

John Wallace Allison, M.D. Cincinnati College of Medicine and Surgery, 1877; aged 62; twice a representative from Kankakee County in the Illinois State Legislature; died at his home in Essex, Ill., December 4.

Hiram Parker Trull, M.D. University of Buffalo, N. Y., 1868; aged 73; a member of the Medical Society of the State of New York; died at his home in Williamsville, N. Y., September 14, from arteriosclerosis.

Nathaniel A. Gray (license, Milwaukee, 1899); aged 75; a member of the State Medical Society of Milwaukee and a practitioner since 1867; died at his home in Milwaukee, November 25, from pneumonia.

Stephen Horace Murphy, M.D. Bellevue Hospital Medical College, 1879; aged 62; until 1904 a practitioner of New York state; died at his home in Spokane, Wash., November 11, from carcinoma of the palate.

Francis O. Hawley, M.D. University of Edinburgh, Scotland, 1868; aged 69; city physician and health officer of Charlotte, N. C.; died at his home in that city, September 14, from cerebral hemorrhage.

C. Beverly Martin, M.D. Hospital College of Medicine, Louisville, 1903; aged 35; a member of the Kentucky State Medical Association; died suddenly at his home in Greenville, Ky., December 1.

Lewis Lanzer, M.D. Eclectic Medical College of the City of New York, 1892; University of Tennessee, Nashville, 1896; aged 50; died at his home in Brooklyn, December 3, from diabetes.

James S. Miller, M.D. University of Louisville, Ky., 1877; aged 62; president of the Titus County (Texas) Medical Society in 1910; died at his home in Mt. Pleasant, Texas, November 28.

Jule E. Marcus, M.D. Cincinnati College of Medicine and Surgery, 1871; aged 64; a member of the Ohio State Medical Association; died at his home in Walnut Hill, Cincinnati, December 6.

Alexander C. Faivre (license, Crawford County, Pa., 1881), aged 78; for many years a practitioner of Meadville, Pa.; died at the home of his daughter in that city, November 26.

Abraham Turner Fulton, M.D. New York University, New York City, 1882; aged 60; of Mount Vernon, Ohio; died in the Mount Vernon Hospital, November 29, from nephritis.

Erner Jones, M.D. Memphis Hospital Medical College, 1882; aged 38; formerly a member of the Arkansas Medical Society; died at his home in Harrell, Ark., November 28.

Brice M. Sprayberry, M.D. Georgia College of Eclectic Medicine and Surgery, Atlanta, 1882; aged 68; died at his home near Ellenwood, Ga., December 4, from nephritis.

Gabriel F. Thornhill, M.D. Hering Medical College, Chicago, 1898; aged 56; of Paris, Texas; died suddenly, in his automobile, December 6, from cerebral hemorrhage.

Joseph A. Kohout, M.D. University of Nebraska, Omaha, 1905; aged 35; formerly of Ord, Neb.; died at his home in Cuba, Kan., about November 10, from tuberculosis.

George Besson McCosh, M.D. Rush Medical College, 1880; aged 58; a practitioner and druggist of Morris, Ill.; died at his home in that place, December 5.

George Henry Wilkins, M.D. New York Homeopathic Medical College, New York City, 1883; aged 60; died at his home in Newtonville, Mass., November 17.

Bernhardt S. Schwarz, M.D. American Medical College, St. Louis, 1897; aged 74; formerly of Kansas City; died at his home in San Francisco, December 6.

Wesley Queen, M.D. Physio-Medical Institute, Cincinnati, 1864; aged 79; of Lincoln, Neb.; died at his home in that city, December 12, from senile debility.

Joseph Hormisdas Boucher, M.D. Laval University, Montreal, 1884; aged 59; died at his home in Woonsocket, R. I., September 25, from arteriosclerosis.

Henry Miller Hewitt, M.D. Rush Medical College, 1878; of Franklin Grove, Ill., and Chicago; died at the home of his aunt in Dixon, Ill., November 29.

Onofrio Abruzzo, M.D. College of Physicians and Surgeons in the City of New York, 1883; aged 74; died at his home in Brooklyn, December 7.

Thomas Jefferson Slayden, M.D. Vanderbilt University, Nashville, Tenn., 1887; aged 55; died at his home in St. Bethlehem, Tenn., December 1.

V. R. Kneberg, M.D. Homeopathic Medical College of St. Louis, 1889; aged 66; died at her home in Chetoka, Kan., November 16, from peritonitis.

William Martin Moran, M.D. Bellevue Hospital Medical College, 1887; aged 61; died at his home in Boston, September 2, from angina pectoris.

George Slocomb Wilson, M.D. Eclectic Medical College of the City of New York, 1881; aged 76; died at his home in Boston, November 30.

John B. DesRochers (license, Washington, 1889), aged 66; formerly of Spokane, Wash.; died at his home in Tacoma, Wash., December 2.

Ella M. Fowle, M.D. Hahnemann Medical College, Chicago, 1893; aged 61; died at her home in Denver, November 25, from carcinoma.

Henry T. Fisher, M.D. Lincoln Memorial University, Knoxville, Tenn., 1891; aged 67; died at his home in Knoxville, November 27.

John E. Robinson, M.D. Louisville Medical College, 1876; aged 63; died at his home in Bethany, Miss., November 9, from paresis.

Thomas R. Allen, M.D. Homeopathic Hospital College, Cleveland, 1866; aged 71; of Ionia, Mich.; died in Chicago, December 4.

Stanard D. Harris (license, Michigan, nineteen years' practice, 1900), aged 79; died at his home in Holly, Mich., December 1.

Charles F. Burger (license, years of practice, Michigan, 1900), aged 84; died at his home in St. Clair, Mich., December 2.

Silas C. Myers (license, years of practice, Iowa, 1887), aged 64; died at his home in Waterloo, Iowa, November 29.

Albo Miller, M.D. Jenner Medical College, Chicago, 1904; aged 51; died at his home, December 1, from heart disease.

The Propaganda for Reform

IN THIS DEPARTMENT APPEAR REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY AND OF THE ASSOCIATION LABORATORY, TOGETHER WITH OTHER MATTER TENDING TO AID INTELLIGENT PRESCRIBING AND TO OPPOSE MEDICAL FRAUD ON THE PUBLIC AND ON THE PROFESSION

POSLAM AND SOME OFFICIAL OINTMENTS

The following inquiry was recently made by a physician who asked that his name be omitted:

"One of my patients is anxious to learn something about Poslam, an alleged eczema cure. I should like to know if the composition of Poslam has ever been published. Are there any official products similar to it?"

Poslam was discussed in THE JOURNAL, May 22, 1909, page 1678 and on page 612 of "Nostrums and Quackery" (Second Edition). The results of a chemical analysis of this preparation made in the A. M. A. Chemical Laboratory as published in these articles indicated that Poslam consisted of:

Zinc oxid	12.01 parts
Sulphur	6.67 parts
Corn starch	22.00 parts
Tar oil	15.18 parts
Menthol	
Salicylic acid	
Fatty base, of each sufficient to make	100.00 parts

The results of the analysis were commented on as follows: "From the results of the analysis it can be seen that the preparation depends for its action on such simple remedies as zinc oxid, sulphur and oil of tar. These have long been used and known as more or less effectual remedies for the treatment of skin affections, but certainly do not warrant such claims as are made in the advertising matter sent out with poslam stating it to be 'The newest medical discovery for the treatment of eczema and all other skin affections' and '. . . entirely different from anything yet used. . . .'"

For skin affections which may be benefited by ointments the official pastes and unguents should be kept in mind. Needless to say these are as effective as the proprietary products and have the added advantage of being of known and more uniform composition. Among the pastes may be mentioned:

LASSAR'S NAPHTHOL PASTE
(Pasta Naphtholi, Lassar)

	gm. or c.c.	
Betanaphthol (U. S. P.), in very fine powder	10	gr. xlviij
Precipitated sulphur (U. S. P.)	50	ʒ iv
Petrolatum (U. S. P.)	20	ʒ iss
Soft soap (U. S. P.) sufficient to make	100	ʒ j

Triturate the betanaphthol and sulphur with the petrolatum and then incorporate the soft soap with the mixture.

LASSAR'S MILD RESORCIN PASTE
(Pasta Resorcini Mitis, Lassar)

	gm. or c.c.	
Resorcinol (U. S. P.)	10	gr. xlviij
Zinc oxid	25	ʒ ij
Starch	25	ʒ ij
Liquid petrolatum (U. S. P.) sufficient to make	100	ʒ j

Thoroughly levigate the zinc oxid with sufficient of the liquid petrolatum to make a thin paste. Reduce the resorcin to a very fine powder, mix with the starch and add the mixture to the zinc oxid paste, triturating until a uniformly smooth mixture is obtained. Then add the remainder of the liquid petrolatum, and incorporate it thoroughly.

LASSAR'S ZINC-SALICYL PASTE
(Pasta Zinci, Lassar)

	gm. or c.c.	
Salicylic acid, in fine powder	2	gr. xx
Zinc oxid	24	ʒ ij
Starch	24	ʒ ij
White petrolatum (U. S. P.) sufficient to make	100	ʒ j

Thoroughly levigate the zinc oxid with a portion of the petrolatum; then add the salicylic acid, the starch and the remaining petrolatum, and triturate until a perfectly smooth mixture is obtained.

UNNA'S SOFT ZINC PASTE
(Pasta Zinci Mollis, Unna)

	gm. or c.c.	
Zinc oxid	20	ʒ ij
Calcium carbonate	20	ʒ ij
Linseed oil	20	ʒ ij
Lime water, sufficient to make	100	ʒ j

Thoroughly levigate the zinc oxid and the calcium carbonate with the linseed oil, gradually added, so as to form a perfectly smooth mixture, then incorporate the lime water by trituration.

UNNA'S SULPHURATED ZINC PASTE
(Pasta Zinci Sulphurata, Unna)

	gm. or c.c.	
Zinc oxid	15	gr. lxxij
Precipitated sulphur (U. S. P.)	10	gr. xlviij
Silicic acid	5	gr. xxiv
Benzoinated lard (U. S. P.) sufficient to make	100	ʒ j

Thoroughly levigate the zinc oxid with a small portion of the benzoinated lard; the silicic acid with another, and the precipitated sulphur with a third portion. Mix the three portions until a uniformly smooth mixture results, and thoroughly incorporate the remainder of the benzoinated lard.

COMPOUND RESORCIN OINTMENT
(Unguentum Resorcini Compositum)

	gm. or c.c.	
Resorcinol (U. S. P.)	6	gr. xxx
Zinc oxid	6	gr. xxx
Bismuth subnitrate	6	gr. xxx
Oil of cade	12	ʒ j
Paraffin	10	ʒ ss
Petrolatum	25	ʒ ij
Hydrous wool fat, sufficient to make	100	ʒ j

Triturate the resorcinol, zinc oxid, and bismuth subnitrate with a small quantity of the hydrous wool fat, until a perfectly smooth mixture is obtained. Incorporate this with the remainder of the wool fat, add the paraffin and petrolatum, previously melted together, and lastly, the oil of cade. Mix intimately, and preserve the ointment in containers protected from the light.

COMPOUND SULPHUR OINTMENT
(Unguentum Sulphuris Compositum)

	gm. or c.c.	
Precipitated calcium carbonate	10	gr. xlviij
Sublimed sulphur	15	gr. lxxij
Oil of cade	15	gr. lxxij
Soft soap (U. S. P.)	30	ʒ ij
Lard, sufficient to make	100	ʒ j

Mix the lard with the soft soap and oil of cade. Then gradually incorporate the sublimed sulphur and precipitated calcium carbonate.

COMPOUND TAR OINTMENT
(Unguentum Picis Compositum)

	gm. or c.c.	
Oil of tar	4	gr. xx
Tincture of benzoin (U. S. P.)	2	gr. x
Zinc oxid	3	gr. xv
Yellow wax	25	ʒ ij
Lard	32	ʒ iiss
Cotton seed oil, sufficient to make	100	ʒ j

Melt the yellow wax and lard with the cotton seed oil at a gentle heat. Add the tincture of benzoin, and continue heating until all the alcohol has evaporated. Then withdraw the heat, add the oil of tar, and finally the zinc oxid, incorporating the latter thoroughly, so that on cooling, a smooth, homogeneous ointment may result.

Correspondence

Effects of Athletic Competition on Childbirth

To the Editor:—There seems to be a division of opinion among those interested in physical education as to the effects of strenuous athletic competition during adolescence on parturition. The consensus of opinion, apparently supported by the fact that the foreign-born American woman or those accustomed to hard life have an easier labor than the American woman of nervous temperament, seems to be that athletics are beneficial at all times, except possibly at the menstrual periods.

Besides the many factors, such as heredity, increased sensory conduction and reception, deficient muscular forces, etc., that influence childbirth, I believe there is a marked difference on the pelvis in the physiologic effect of the exercise performed.

The type of exercise (work) of the working woman has its predominating effect on the musculatures of the trunk and upper extremities. The movements are invariably rhythmic,

slow and continued over a long period of time with a minimum stress and strain on the pelvis. The character of athletic movements is entirely different. Here the body weight is quickly shifted from one foot to the other, and there are sudden stops, starts and twists, with a maximum stress and strain on the pelvis.

In the latter condition the pelvis is apt to show more rigidity, and there is a generally increased muscular development, which is better adapted to sudden spasmodic effort. In the former case, there is a maximum muscular development with a minimum rigidity of the pelvis, and the musculature is more trained to continuous muscular exertion, which more readily meets the demands of labor.

I have been endeavoring to obtain data confirming or disproving the foregoing theory, and should like to hear from others interested in the subject. I have prepared for circulation a questionnaire and case-record blank, copies of which I shall be glad to furnish on request. The questionnaire covers the following points:

1. Is labor more difficult in the athletic girl, and if so, why?
2. If strenuous athletics are detrimental, what form of exercise would you advise?
3. At what period in a girl's life is the most injury done?

The history and record blank is a tabulated form to obtain:

1. Paternal and maternal histories as to physical characteristics.
2. Type, duration, etc., of the forms of athletics engaged in.
3. Character of the pelvis, of labor, etc.
4. Size, health, etc., of child.

G. BIGELOW MULLISON, M.D.,
5615 Girard Avenue, Philadelphia.

Queries and Minor Notes

ANONYMOUS COMMUNICATIONS and queries on postal cards will not be noticed. Every letter must contain the writer's name and address, but these will be omitted, on request.

CU-CO-BA, TARRANT

To the Editor:—What is there to all this?

W. E. DELANEY, M.D., Williamsport, Pa.

ANSWER.—"This" is a circular letter in which it is asserted that:

"More favorable results are reported from the administration of CU-CO-BA, Tarrant, in cases of pyelitis, inflammation of the bladder, urethritis, urethro-blenorrhea, vaginitis, leucorrhea than from any other combination."

Cu-co-ba, Tarrant (Tarrant Company, New York) is described as "a preparation of the purest and most highly esteemed variety of balsam copaiba with a concentrated extract of cubebs." It appears to be one of the balsamic preparations for internal use that formerly were in vogue as a routine measure in the treatment of gonorrhea. Little reliance is now placed in this form of treatment by the medical profession, but a portion of the public still has faith in it.

LITERATURE ON WAR SURGERY

To the Editor:—Please give me information or send me literature on war surgery.

ROBERT W. SHIPP, M.D., Austin, Texas.

ANSWER.—The following is a list of references to articles which have been published in THE JOURNAL on this subject. The index of the current literature for the past year and a half contains numerous references under the headings of war, wounded soldiers, etc.

Mills, L.: Projectile Wounds of the Head: Experiences During Recent Service in Austria, THE JOURNAL, Oct. 23, 1915, p. 1424.
Wounds and Hydrogen Peroxid, editorial, THE JOURNAL, Sept. 4, 1915, p. 878.
Sir William Osler on Wounds and Diseases in War, THE JOURNAL, Aug. 7, 1915, p. 543.
Dreesen, W. L.: Experiences in Military Surgery, THE JOURNAL, July 24, 1915, p. 296.
Jablons, B.: Pathology of War Surgery, THE JOURNAL, June 19, 1915, p. 2045.
War Experiences With Infected Wounds, editorial, THE JOURNAL, May 22, 1915, p. 1764.
Mills, L.: Wounds Received in Battle, THE JOURNAL, April 10, 1915, p. 1224.
War Surgery, editorial, THE JOURNAL, March 13, 1915, p. 912.
Current Aspects of Military Surgery, editorial, THE JOURNAL, March 6, 1915, p. 832.
Blech, G. M.: Military Surgery, THE JOURNAL, Jan. 9, 1915, p. 167.
Hoguet, J. P.: Observations on Military Surgery in the Early Weeks of the War, THE JOURNAL, Dec. 19, 1914, p. 2194.

HYDROCHLORIC ACID IN GASTRIC JUICE—NICHROME WIRE AS A SUBSTITUTE FOR PLATINUM

To the Editor:—1. Kindly inform me what are considered the normal free hydrochloric acid findings in gastric juice. I was taught and have always considered from 25 to 30 tenth-normal sodium hydroxid to be about correct. Niles places it at 0.2 per cent. hydrochloric acid, but also states it as being from 15 to 25 tenth-normal sodium hydroxid, which is not quite 0.1 per cent. Webster says from 0.2 to 0.3 per cent. hydrochloric acid, and gives his figures as from 50 to 55 or from 0.18 to 0.2 per cent. hydrochloric acid. Lately articles in THE JOURNAL place it as high as 0.5 per cent. Will you kindly clear this muddle for me?

2. Please supply me with the name of the wire which is used in place of platinum.

S. ROY MILLS, M.D., Braddock, Pa.

ANSWER.—1. It is fairly safe to assert that the average of free hydrochloric acid in normal pure gastric juice is higher than it was formerly stated to be. Recent examinations of pure human gastric juice by Carlson show that the total hydrochloric acid averages 0.45 per cent. and the free hydrochloric acid 0.4 per cent. These figures apply to gastric juice obtained from one person, but data furnished from other sources indicate that they approximate the usual averages for pure gastric juice.

2. Nichrome wire.

MEDICAL HISTORY

To the Editor:—1. Do any of the medical colleges in the United States have chairs of medical history?

2. Please give me a list of the best books on the history of medicine.

3. Please refer me to magazines dealing with medical history or publications which have a department of medical history.

I. L. M.

ANSWER.—1. No. Fourteen schools offer courses of from three to thirty hours, and these are usually optional.

2. Such a list appeared in THE JOURNAL, Feb. 7, 1914.

3. Publications:

Janus: Archives internationales pour l'histoire de la médecine et pour la géographie médicale, published in Amsterdam, Bimonthly.
Mitteilungen zur Geschichte der Medizin und der Naturwissenschaften, Hamburg.
Proceedings of the Royal Society of Medicine, published by Longmans, Green & Co., New York, Section on History of Medicine.

ORTHOFORM-NEW UNDER THE HARRISON LAW

To the Editor:—Please tell me whether the sale of orthoform comes under the Harrison law. The local druggist has been instructed by the manufacturers that the status of orthoform is undecided.

J. S. WHITE, M.D., St. Paul.

ANSWER.—As orthoform is no longer on the market, we take it that our correspondent's inquiry refers to "orthoform-new." As stated in THE JOURNAL, Nov. 20, 1915, p. 1837, "Treasury Decision 2194 requires the registration of any 'artificial substance or preparation which is or may be substituted for cocain, alpha or beta eucaine, or any of their salts as ordinarily prescribed or used. . . .'" New and Nonofficial Remedies, 1915, p. 35, states that "orthoform-new is a local anesthetic, resembling cocaine in its local action. . . ." It would seem that the treasury decision contemplates registration of orthoform-new.

ARTICLES ON INTESTINAL CAUSES OF EPILEPSY

To the Editor:—Where can I find recent literature on the intestinal causes of epilepsy?

AUSTIN M. GROVE, M.D., York, Pa.

ANSWER.—The following is a list of articles on this subject:

Cornwall, E. E.: Clinical Study of Case of Epilepsy Apparently of Intestinal Origin, *Arch. Diagnosis*, July, 1915; abstr., THE JOURNAL Oct. 16, 1915, p. 1404.
Francaviglia, M. C.: Reflex Epilepsy from Intestinal Helminthiasis, *Policlinico*, Rome, Aug. 1, 1915; abstr., THE JOURNAL, Sept. 4, 1915, p. 913.
McCoy, W. K.: Intestinal Intoxication: Headaches and Epilepsy, *Lancet-Clinic*, April 24, 1915.
Reed, C. A. L.: Probable Cause and Logical Treatment of Epilepsy, THE JOURNAL, March 27, 1915, p. 1047.
Powers, H.: Rôle of Gastric and Intestinal Stasis in Some Cases of Epilepsy, *Boston Med. and Surg. Jour.*, Aug. 7, 1913; abstr., THE JOURNAL, Sept. 6, 1913, p. 807.
Berger, F.: Epileptic Seizures from Appendicitis, *Med. Klin.*, Feb. 18, 1912.
Axtell, W. H.: Acute Angulation and Flexure of the Sigmoid a Causative Factor in Epilepsy, *Am. Jour. Surg.*, December, 1910; abstr., THE JOURNAL, Jan. 7, 1911, p. 74; *Am. Jour. Surg.*, August, 1911; abstr., THE JOURNAL, Aug. 26, 1911, p. 767.
Skoog, A. L.: Focal Epilepsy, *Surg., Gynec. and Obst.*, December, 1911.

Medical Education and State Boards of Registration

COMING EXAMINATIONS

ALABAMA: Montgomery, Jan. 11, 1916. Sec., Dr. W. H. Sanders, Montgomery.

ALASKA: Juneau, Jan. 4, 1916. Sec., Dr. Harry C. DeVighne, Juneau.

ARIZONA: Phoenix, Jan. 4-5, 1916. Sec., Dr. John Wix Thomas, National Bank of Arizona Bldg., Phoenix.

CALIFORNIA: Sacramento, Jan. 11, 1916. Sec., Dr. Charles B. Pinkham, Room 527 Forum Bldg., Sacramento.

COLORADO: Denver, Jan. 4, 1916. Sec., Dr. David A. Strickler, 612 Empire Bldg., Denver.

DISTRICT OF COLUMBIA: Washington, Jan. 11, 1916. Sec., Dr. Edgar P. Copeland, The Rockingham, Washington.

ILLINOIS: Chicago, Jan. 13-15, 1916. Sec., Dr. C. St. Clair Drake, Springfield.

INDIANA: Indianapolis, Jan. 11, 1916. Sec., Dr. W. T. Gott, 84 State House, Indianapolis.

MINNESOTA: Minneapolis, Jan. 4-7, 1916. Sec., Dr. Thomas S. McDavitt, 814 Lowry Bldg., St. Paul.

NEW MEXICO: Santa Fé, Jan. 10, 1916. Sec., Dr. W. E. Kaser, East Las Vegas.

NEW YORK: Albany, Buffalo, New York and Syracuse, Jan. 25-28, 1916. Chief, Examinations Division, Mr. Harlan H. Horner, State Education Bldg., Albany.

NORTH DAKOTA: Grand Forks, Jan. 4-7, 1916. Sec., Dr. G. M. Williamson, Grand Forks.

OKLAHOMA: Oklahoma City, Jan. 11-12, 1916. Sec., Dr. R. V. Smith, 502 Daniel Bldg., Tulsa.

OREGON: Portland, Jan. 4, 1916. Sec., Dr. L. H. Hamilton, Medical Bldg., Portland.

PENNSYLVANIA: Philadelphia, Jan. 18-20, 1916. Sec., Mr. Nathan C. Schaeffer, Harrisburg.

RHODE ISLAND: Providence, Jan. 6-7, 1916. Sec., Dr. Gardner T. Swarts, Providence.

SOUTH DAKOTA: Pierre, Jan. 11, 1916. Sec., Dr. P. B. Jenkins, Wanbay.

UTAH: Salt Lake City, Jan. 3, 1916. Sec., Dr. G. F. Harding, 407 Templeton Bldg., Salt Lake City.

WASHINGTON: Spokane, Jan. 4, 1916. Sec., Dr. C. N. Suttner, Baker Bldg., Walla Walla.

WISCONSIN: Madison, Jan. 11, 1916. Sec., Dr. J. M. Dodd, 220 E. Second St., Ashland.

Texas June Report

Dr. M. P. McElhannon, secretary of the Texas State Board of Medical Examiners, reports the practical and written examination held at Austin, June 22-24, 1915. The total number of subjects examined in was 12; total number of questions asked, 132; percentage required to pass, 75. The total number of candidates examined was 139, of whom 136 passed, including 15 osteopaths, and 3 failed, including 1 osteopath. Thirty-three candidates were licensed through reciprocity. Seven candidates were granted reregistration licenses. The following colleges were represented:

PASSED

College	Year Grad.	Per Cent.
Chicago College of Medicine and Surgery	(1915)	90
Rush Medical College	(1910)	88
University of Louisville	(1915)	81, 89
Tulane University of Louisiana	(1885) 75; (1902) 83, 89; (1907) 89; (1910) 82; (1915) 86, 86, 88, 89, 89, 89, 90, 91, 92	
Johns Hopkins University	(1913)	88, 90
Harvard University	(1908) 84; (1915)	86
St. Louis Coll. of Phys. and Surgs.	(1914) 78; (1915)	76
Columbia University, College of Phys. and Surgs.	(1911)	92
New York Homeo. Med. Coll. and Flower Hosp.	(1915)	87
University of Pennsylvania	(1915)	83
Meharry Medical College	(1915) 76, 79, 81, 86, 86, 87, 89	
University of Tennessee	(1912) 75; (1914) 86, 86; (1915) 76, 83, 84, 86, 92	
Vanderbilt University	(1913) 88; (1914) 81, 83; (1915) 80, 81, 84, 84, 86, 87, 88, 88, 90, 91, 92.	
Baylor University	(1915) 79, 81, 81, 83, 84, 84, 85, 86, 87, 87, 87, 89, 91, 92, 93.	
Southern Methodist University	(1915) 84, 85, 87, 90, 93	
Fort Worth School of Medicine	(1913) 81, 81, 82, 84, 84, 85, 86, 86, 87, 87, 92.	
University of Texas	(1914) 92; (1915) 80, 82, 83, 84, 84, 84, 85, 85, 86, 87, 87, 87, 88, 88, 89, 89, 89, 89, 89, 90, 90, 91, 91, 91, 93, 93.	
National School of Medicine, Mexico	(1887) 75; (1893) 83; (1900) 82; (1901) 81.	
School of Medicine of Nuova Leon, Monterey	(1899)	78

FAILED

Chicago College of Medicine and Surgery	(1914)	*
University of Tennessee	(1915)	*

LICENSED THROUGH RECIPROCITY

College	Year Grad.	Reciprocity with
Arkansas Industrial University	(1889)	Oklahoma
Atlanta College of Physicians and Surgeons	(1902)	Oklahoma
Atlanta Medical College	(1894)	Georgia
College of Physicians and Surgeons, Chicago	(1905)	Arkansas
Jenner Medical College	(1912)	Arkansas
Rush Medical College	(1902)	Wisconsin
Kentucky School of Medicine	(1892)	Georgia
Louisville Medical College	(1896)	Georgia
University of Louisville	(1913)	W. Virginia
Maryland Medical College	(1901)	W. Virginia
Tufts College Medical School	(1903)	Missouri
Detroit College of Medicine	(1897)	Michigan
University of Michigan Medical School		Minnesota
University of Minnesota	(1907)	N. Dakota
Eclectic Medical University, Cincinnati	(1914)	Arkansas
Kansas City Homeo. Med. College	(1899)	Missouri
St. Louis University	(1912)	Missouri
Medical College of Ohio	(1907)	Ohio
Miami Medical College	(1881)	Ohio
Ohio Medical University	(1898)	Ohio
Western Reserve University	(1893)	Ohio
Hahnemann Medical Coll. and Hosp., Philadelphia	(1907)	Maryland
University of Pennsylvania	(1913)	Maryland
Meharry Medical College	(1904)	Missouri
Memphis Hospital Medical College	(1897)	Mississippi
Vanderbilt University	(1888) Kentucky; (1893) Indiana; (1900)	Kentucky
Baylor University	(1908)	Oklahoma
Fort Worth School of Medicine	(1906)	Oklahoma

LICENSED BY ORDER OF THE BOARD

Two graduates of the National School of Mexico were granted reciprocity licenses by the order of the board. The years of graduation were not given.

* No grade given.

Michigan June Report

Dr. B. D. Harison, secretary of the Michigan State Board of Registration in Medicine, reports the oral and written examination held at Ann Arbor, June 8-10, 1915. The total number of subjects examined in was 14; total number of questions asked, 100; percentage required to pass, 75. The total number of candidates examined was 59, of whom 55 passed and 4 failed. The following colleges were represented:

PASSED

College	Year Grad.	Per Cent.
Rush Medical College	(1915)	88.8
Louisville Medical College	(1897)	75
University of Michigan Medical School	(1915) 79, 80.9, 81, 81.2, 81.5, 81.7, 82.1, 82.4, 82.8, 83.2, 83.2, 83.4, 83.6, 83.8, 83.9, 84.1, 84.9, 85.2, 85.2, 85.7, 85.8, 85.8, 85.8, 86.1, 86.6, 86.7, 86.9, 87, 87.1, 87.4, 87.5, 87.6, 88, 88.2, 88.9, 89.3, 89.5, 89.7, 91.3.	
University of Michigan Homeo. Med. School	(1915) 75, 76.7, 80.2, 82, 82.6, 83.5, 83.6, 84.8, 85.1, 85.1.	
Eclectic Medical College, Cincinnati	(1915)	82
University of Pennsylvania	(1915) 83.6,	91.7
University of Pittsburgh	(1915)	82.9

FAILED

University of Michigan Medical School	(1915)	*
University of Michigan Homeo. Med. School	(1915)	*, *, *

* Conditioned in pathology; no grade given.

Oregon July Report

Dr. J. L. Hamilton, secretary of the Oregon State Board of Medical Examiners, reports the written examination held at Portland, July 6-8, 1915. The total number of subjects examined in was 15; total number of questions asked, 100; percentage required to pass, 75. The total number of candidates examined was 49, of whom 31 passed and 18 failed. The following colleges were represented:

PASSED

College	Year Grad.	Total No. Licensed
California Eclectic Medical College	(1914)	1
College of Physicians and Surgeons, San Francisco	(1915)	1
Bennett College of Eclectic Medicine and Surgery	(1884)	1
Chicago College of Medicine and Surgery	(1914)	1
Hahnemann Medical College and Hospital, Chicago	(1894)	1
Northwestern University	(1905) (1914)	2
Rush Medical College	(1911)	1
University of Louisville	(1913)	1
Baltimore Medical College	(1901)	1
University of Michigan, Homeo. Medical School	(1913)	1
St. Louis College of Physicians and Surgeons	(1915)	1
St. Louis University	(1908)	1
University Medical College, Kansas City	(1910)	1
University of Oregon	(1915)	11
Hahnemann Medical Coll. and Hosp., Philadelphia	(1915)	1
Jefferson Medical College	(1912, 2) (1913)	3
Woman's Medical College of Pennsylvania	(1909)	1
McGill University	(1914)	1

FAILED

College of Medical Evangelists	(1914)	1
College of Physicians and Surgeons, San Francisco	(1915)	1
George Washington University	(1907)	1
Bennett Medical College	(1913)	1
Chicago College of Medicine and Surgery	(1914)	1
Indiana University	(1909)	1
Louisville and Hospital Medical College	(1908)	1
St. Louis College of Physicians and Surgeons	(1904) (1915)	2
St. Louis University	(1905)	1
University of Oregon	(1908) (1910) (1915, 4)	6
Willamette University	(1905) (1907)	2

Society Proceedings

COMING MEETINGS

American Association of Anatomists, Chicago, Dec. 27-29.
American Physiological Society, Boston, Dec. 27-30.
Society of American Bacteriologists, Urbana, Ill., Dec. 28-30.

CHICAGO GYNECOLOGICAL SOCIETY

Stated Meeting, held Nov. 19, 1915

DR. CHANNING W. BARRETT in the Chair

The Induction of Labor at Term

DR. CHARLES B. REED: Can we determine whether or not the child has reached maturity, thus fixing the time at which labor should occur? A child weighing more than 8 pounds is past maturity in 70 per cent. of cases. We accept seventeen weeks from conception as the day of quickening and forty-two weeks as the culmination of pregnancy. Sometimes a week more is allowed, depending on the number of labors which the patient has had. The work may be done under any aseptic environment, but the hospital is preferable. Attention should be given to the bowels the night before, and in the morning the usual obstetric preparation of the genitalia should be made. Under the strictest asepsis a Voorhees bag is introduced without rupture of the membranes, the patient being in the exaggerated lithotomy position. Anesthesia is necessary only occasionally, even in primiparas. If the os is not sufficiently patulous to admit the bag, it should be dilated. The bag is rolled up to a compact mass, seized with a Péan forceps and passed into the uterus and filled with an ordinary hand syringe. If the pains do not start in an hour, a weight of a pound or two is attached to the bag and hung over the foot of the bed. Usually in from one to two hours the labor begins. The bag remains for a variable period, rarely more than four hours, when it is expelled with strong pains. Dilatation is practically complete. The head follows the bag down, the membranes rupture and the second stage begins. From now on the case is managed according to general obstetric principles. If the pains are weak and shallow, pituitary extract is given; if strong and regular, morphin and scopolamin, gas or chloroform may be used. The first stage has been shortened and controlled. The bag acts as a dynamic stimulant to the contractions as well as a mechanical aid to dilatation, and preserves the membranes from rupture until physiologic rupture occurs.

It is believed that shortening the labor process and the preservation of maternal vitality make for immunity and prevent the infection that might follow a prolonged labor. The second danger is the possibility of prematurity. This happened once. The case was not supervised, and an intern, supposed to be reliable, measured the uterus instead of the fetus. The result was a seven months' child. It has been urged as an objection to the bag that it frequently changes the location of the presenting part. This occurred two or three times, but was not unfavorable.

In a series of 100 cases, the results were as follows: primiparas, 35; multiparas, 65; average duration of labor, seven and three-quarters hours; shortest labor, fifty-five minutes; longest, thirty hours in a primipara with a hard, cartilaginous cervix, and twenty-eight hours in a multipara with cicatricial tissue in the cervix. The bag broke six times, and was reinserted three times; the average time for expulsion of the bag was three hours and twenty minutes; membranes ruptured by bag, eleven; maternal deaths, two, one from placenta praevia and one from pneumonia eight days after labor; average weight of children, 7 pounds, 7 ounces; smallest, 5 pounds; heaviest, 10 pounds, 5 ounces; seven babies died, one a child of a primipara after a spontaneous labor of sixteen and a half hours; a baby born in asphyxia pallida, and revived with difficulty, died eight hours later; second, of a multipara; labor eleven and a half hours; blue baby; revived, and died suddenly thirty-six hours later; third and fourth children, compression of cord at outlet, one syphilitic; fifth and sixth children, moderately contracted pelvis in a primipara; one occipital posterior position stillborn. This is the only case attributable to the method.

Complications: Version and expression, 3; breech, 4; placenta praevia, 2, and collapse of the arm, 1; moderately contracted pelvis, external conjugate 8 cm., 6; stenosis, 1; motor insufficiency, 1; lacerations, 17; grave albuminuria, 1; forceps, axis traction, 2; low forceps for occipital posterior, 9; deep transverse arrest, 8; insufficiency of power, 4; total, 23. Elevation of temperature, 7.

DISCUSSION

DR. J. CLARENCE WEBSTER: The induction of labor at a calculated date is not new. I should like to emphasize that there is no means of calculating the exact age of the fetus in utero, because no one yet knows when conception begins. There is always a period of uncertainty of one or two or three weeks; consequently the determination of the time of maturity is guesswork to a considerable extent even in the hands of the expert. A 4½ or 5 pound child may be just as well developed as one weighing 7 or 8 pounds, and the measurements will be different. One good object that can be gained by this procedure is the prevention of an extension beyond term, which is so bad for many mothers and children. I employed a similar technic for many years, but in later years I have abandoned forceps and have used the fingers. In primiparas I always dilate the vagina with the cone-shaped hand covered with a rubber glove, and I then study the condition of the cervix. In the great majority of primiparas or multiparas one can dilate the cervix with the finger. I have seen a very bad tear caused by the use of the vulsella on the cervix in this process, and I rarely use them. Cases with rigid cervix I do not consider fit for the bag at all. I think one of Dr. Reed's long labors was a typical case of rigid cervix. That is a case for a vaginal or abdominal cesarean section, but not for dilatation. In reference to the shortness of the labor, for sixteen years I have generally introduced the bag in the forenoon. In the great majority of cases the labors have not come off until late in the evening, toward midnight, or the next morning. I think a very small percentage of labors have come off within six hours. In the great majority of these cases no weight was attached to the bag. The attachment of a weight has advantages, if one wishes to insure the stimulation of the uterus and the early development of good pains. One point that Dr. Reed did not mention is that in those cases of first stage slight pains that keep the woman in uncertainty and misery and spoil sleep for a long number of hours, the introduction of a Voorhees bag is one of the very best clinical measures that can be adopted to shorten this period and bring about dilatation.

DR. CHARLES E. PADDOCK: If Dr. Reed intends this as an instruction to us to deliver every case at term or as near term as we can judge the case, then we are meddling somewhat with obstetric practice. In the attempt to carry out this line of treatment we will have many failures. I cannot find the cervix dilated or dilated sufficiently in every primipara to admit a bag in the manner described. I cannot do it without at first dilating at least one third of the primiparas that come to me, and without putting the majority of them under an anesthetic to do it. In about nine tenths of the cases in which I have seen the woman throughout pregnancy I know when she is at term, and I advise that she go to the hospital and have the pregnancy interrupted, provided the cervix is in such shape that it can be done without any great traumatism to the mother or danger to the child. But to send out such a teaching to the world as the treatment to pursue I do not believe is right.

DR. RUDOLPH W. HOLMES: I have been hearing rumors of Dr. Reed's method, and I have been very skeptical about it. I could not believe it possible that any one would want to induce labor in every case. People may consent to the procedure, and if there is failure there will be intense criticism, deep prejudice will be aroused, and great hardship will be worked to physicians. I think it is ill advised to make it a leading practice in obstetrics. I am convinced that a woman postmature is as rare as flies on the north pole. Dr. Reed

has made the mistake of delivering a seven months' baby, and I know of a cesarean section that was done here at seven months. I have used the bag in 100 cases. In one case of placenta praevia I had the placenta out and the uterus tamponed in ten minutes. In another case I had the bag in five days and then had to secure delivery by cutting. Each bag would work for a time and then the cervix would go back. The bag does not secure sufficient dilatation—only a little more than half. To put in a large bag is a great volume to put into the uterus, and it will dislodge the head. When the bag comes out, the head, if favorably placed, will slip back into place. But they are dislodged, and the fact that Dr. Reed had several occipito-posterior positions is suggestive. If he follows up his experience, I believe he is going to be convinced that the bag dislodges the head, and when it slips back into the pelvis it will take an abnormal position.

DR. RACHEL YARROS: We have been trained to leave our obstetric patients alone, or to meddle with them as little as possible. In abnormal cases the bag does not work so remarkably as in Dr. Reed's cases. I have never had a case in a primipara in which the bag worked as successfully, and especially a small bag. It is expelled before there is time for the membranes to rupture or for the baby to be delivered.

DR. N. S. HEANEY: Any method of shortening the first stage of labor without danger to the mother or child is desirable. We have not used traction in connection with the bag according to the method of Dr. Reed, except in placenta praevia, and then just enough weight to stop the hemorrhage. Lately I have been using traction in a larger percentage of cases by means of rubber tubing from a fountain syringe.

DR. FRANK CAREY: I am inclined to let my patients get into labor before I undertake to do anything. I have not been able to tell when a patient is at full term, and until I can do that I shall hardly be inclined to resort to artificial means until the patient is in labor.

DR. R. T. GILLMORE: I have watched Dr. Reed for some time, and I confess that it has taught me to fear the bringing on of labor less than before I was familiar with it. I am inclined to believe Dr. Reed's theory of the patient not being tired out and not having the exhaustion of the nervous elements is an important factor both in the patient's recovery and in the prevention of sepsis. I am going to try it oftener in hospital cases, in which asepsis is perfect and I have better control.

DR. CAREY CULBERTSON: For some months I have used the method in my private cases, pathologic and clinical, at what we call "term." I think all obstetricians will agree that it does not make very much difference, as far as recovery goes, whether a baby is born at 280, 285 or 290 days, or throughout a fourteen-day period. I have been inducing labor after the 280th day, choosing the day when the patient expressed the desire to have the baby. The first stage has been shortened and the entire labor is confined to forty-eight hours, whether the patient is a primipara or a multipara. The second stage is not materially altered, because the bag is out. As far as the displacement of the head is concerned, in multiparas that is not an important factor, because in the average multipara the head is not in the pelvis. I find as a rule that the head returns to the pelvis when the bag is out of the cervix in the vagina. There are occasional cases in which labor is not induced, in which it cannot be induced by any artificial means and the patient must be delivered surgically, but that does not happen oftener than once in twelve or fifteen times. I think we are using a larger bag than Dr. Reed. I have never found it necessary to put the bag in three or four or five times. I should not do it, especially every day. I should allow two or three days to intervene. As a rule, I do not find it necessary to employ traction, but when I do I use the elastic tube. It is important not to make too much traction, and the bag can be too tight in the cervix. A little tension is all that is required. I usually expect contractions to occur immediately after the introduction of the bag. When the bag has been in all night or all day and pains do not come on, I think it best to take the bag out. It certainly should not be left in twenty-four hours.

DR. MARK T. GOLDSTINE: The impression is that the technic of this is simple. I have just the opposite impression. I do not think the introduction of the bag and the management of the case afterward is always as simple as one would be inclined to believe from what has been said here. I would not say that the introduction of the bag is difficult, but the asepsis and carefulness required after the bag is introduced are far from simple, and it requires either the man himself to watch his patient or some one who has had a great deal of experience. Dr. Reed's success I attribute as much to the lack of intravaginal manipulation as to the short labor. In the great majority of cases the only intravaginal manipulation done would be the introduction of the bag. No other vaginal examinations are made. I think that has some bearing on his lack of morbidity. The work will impress a great many men. I should like to see the same procedure tried in a series of normal cases, leaving out the abnormal ones.

DR. CHARLES B. REED: It makes little difference whether the child comes two weeks before full term or not; it does make a difference whether the child is delivered two weeks after the expected time. Dr. Paddock made use of the term "meddlesome obstetrics." I suppose it is. I used to hear the term applied to surgery when some one was going to open an appendiceal abscess. The point is, Are we going to control the situation from the beginning, or shirk responsibility? If we are going to be men we will take the responsibility and take what blame comes to us and not claim to be obstetricians. As to the introductoin of the bag, Dr. Paddock and others manifested an unwillingness to do it without an anesthetic. My associates at the hospital see one bag introduced, and after that they introduce it themselves. My interns will put in the bag without an anesthetic and without any difficulty whatever, provided they have the manual dexterity. Deliver at the time set, in as short a time as possible, and make it as nearly painless as possible. The small bag has been chosen purposely. We have experimented with large sized bags. We have selected the small bag deliberately because we do not want to get complete dilatation. We inaugurate labor and let Nature complete it. Formerly when the bag came out the pains might cease, but now we have pituitary extract, the labor continues and the woman is delivered. The babies do not suffer and the women do not suffer more than a few hours. The technic is important, and I am free to say that the cases do require an unusual amount of attention.

Current Medical Literature

AMERICAN

Titles marked with an asterisk (*) are abstracted below.

American Journal of Medical Sciences, Philadelphia

December, CL, No. 6, pp. 781-936

1 *Complement Fixation in Diagnosis of Pulmonary Tuberculosis. C. F. Craig, U. S. Army.
2 *Landry's Paralysis; Report of Case with Necropsy and Histopathologic Findings. E. D. Fisher, New York.
3 Value of Symptomatic Drug Treatment. J. L. Miller, Chicago.
4 Problems of Nephritis from Clinical Standpoint. A. R. Elliott, Chicago.
5 Chronic Interstitial Nephritis and Arteriosclerosis. O. Klotz, Pittsburgh.
6 Certain Syphilitic Affections of Heart and Aorta. J. M. Anders, Philadelphia.
7 *Heart Cases Showing Vagus Influence. M. H. Sicard and F. S. Mears, New York.
8 "Sugar" Content of Spinal Fluid in Meningitis and Other Diseases. A. H. Hopkins, Philadelphia.
9 *Tubercle Bacilli not Stainable by Ziehl; Their Clinical Significance. C. N. Meader, Denver.
10 *Hodgkin's Disease; Study of Twenty-Five Cases. W. F. Cunningham, New York.
11 Citrate Method of Blood Transfusion in Children. R. Lewisohn, New York.

1. Complement Fixation in Tuberculosis.—Craig believes that in this method we possess a valuable aid in the diagnosis of active tuberculous infection and a guide as to the results of therapeutic measures. The general technic of the complement fixation test for tuberculosis experimented with is that employed in making the Wassermann test. The

antigen employed consists of an extract of several strains of the human tubercle bacillus. A human hemolytic system was employed. As complement guinea-pig blood serum was used, Craig tested the blood of 166 patients suffering from pulmonary tuberculosis. In addition, the blood of 150 syphilitic as well as of 100 patients suffering from other diseases was tested, and also 150 normal individuals who were used as controls. Of the 142 cases of pulmonary tuberculosis that reacted to the test, 119 gave a double-plus reaction and 23 a plus reaction; of the 103 cases of active infection reacting, 87 gave a double-plus reaction and 16 a plus reaction; while of the 39 inactive cases of infection, 32 gave a double-plus reaction and 7 a plus reaction. Of 150 syphilitics tested, all giving a positive Wassermann, not one gave a positive reaction with the antigen employed in the complement fixation test for tuberculosis. Of the patients suffering from other diseases, 100 in number, all gave a negative reaction. The blood serum of 150 individuals in good health and free from tuberculous infection was tested and a negative result was obtained in every instance. The results of the test also demonstrate that while a patient may have a clinically inactive tuberculous infection, the blood often gives a positive complement fixation reaction, and this fact, Craig says, should prove of considerable value in the control of the treatment of the disease.

2. Abstracted in THE JOURNAL, June 12, p. 2013.

7. **Heart Cases Showing Vagus Influence.**—One of the cases cited by Sicard and Meara, a case of simple increased frequency of the heart's action, was controlled and slowed by compression of the right vagus governing the sinus node, the slowed impulses from which were transmitted through junctional tissue to the ventricles, maintaining normal rhythm; this is what one would expect. The other case, one of tachycardia of auricular origin, was slowed by compression of the left vagus.

9. **Tubercle Bacilli Not Stainable by Ziehl.**—In any patient suspected of tuberculosis in whom Ziehl forms cannot be demonstrated, Meader says, it is as important to search for Gram-staining forms as it was for the Ziehl-staining bacilli, and a diagnosis of tuberculosis cannot be certainly excluded until such search has proved negative. The type of case in which they are characteristically present strongly supports the conception that they represent a resistance stage of low virulence, and their presence alone warrants a much more favorable prognosis than does the presence of Ziehl forms. Further, they are probably a definite factor of as yet undetermined importance in the spread of tuberculosis.

10. **Hodgkin's Disease.**—According to Cunningham, the treatment of Hodgkin's disease is excision of all foci of infection and Roentgen rays. Vaccines are of no value. For diagnosis in lymphatic disturbances, more than one gland should be obtained. The following evidence is given to support it as an infection, bacterial or protozoan in origin: (a) the histology is that of an inflammatory reaction; (b) injections of gland emulsions have caused temporary lymphatic enlargement in lower animals (literature); (c) the fever resembles closely that of other infections; (d) the leukocytosis; (e) the exudate when serous surfaces are involved. The specific organism has not been isolated.

American Journal of Physiology, Baltimore

December, XXXIX, No. 2, pp. 131-238

12 *Effect of Chloroform on Factors of Coagulation. G. R. Minot, Boston.
13 Peristalsis and Coordination in Earthworm. W. E. Garrey and A. R. Moore.
14 *Cardio-Inhibitory Center. F. R. Miller and J. T. Bowman, London, Canada.
15 Effects of Aqueous Extracts of Organs on Contractions of Unstriated Muscle Fibers. G. G. Fawcett, J. M. Rahe, G. S. Hackett and J. Rogers, New York.
16 Feeding of Young Chicks on Grain Mixtures of High and Low Lysin Content. G. D. Buckner, E. H. Nollau and J. H. Kastle, Louisville, Ky.
17 Electrical Studies in Mammalian Reflexes. Correlation Between Strength of Stimuli and Direct and Reflex Nerve Response. A. Forbes and A. Gregg, Boston.
18 *Evidence of Vasotonic and Vasoreflex Mechanism. W. T. Porter and A. H. Turner, Boston.

12. **Effect of Chloroform on Factors of Coagulation.**—In his experimental work Minot found that antithrombin is rendered inactive by chlorofofm and ether, thus allowing free thrombin if present in an oxalated plasma to clot fibrinogen. Prothrombin is not converted to thrombin by chloroform. Chloroform can precipitate both fibrinogen and prothrombin from an oxalated plasm. Chloroform does not weaken the action of a solution of pure thrombin. Ether does slightly. Antithrombin could not be recovered from chloroform or ether extracts of serum or plasma, unheated or heated to 60 C., and is not exactly identical to antitrypsin or to Doyon's antithrombin. In one chloroform poisoned rabbit the antithrombin of the blood was decreased below normal.

14. **Cardio-Inhibitory Center.**—The results of the experiments made by Miller and Bowman show that the cardio-inhibitory center is situated in the dorsal vagus nucleus and are thus in harmony with the histologic investigations of Kohnstamm and of van Gehuchten and Molhant.

18. **Vasotonic and Vasoreflex Mechanism.**—The method employed by Porter and Turner consisted in applying curare to the vasomotor center hitherto believed to control both the vasotonic and the vasoreflex function. Curare left the tonus unchanged, while the depressor and the sciatic vasomotor reflexes were more than doubled. Curare thus separated the vasoreflex from the vasotonic function. Certain doses of alcohol leave the tonus unchanged while completely suspending the vasomotor reflexes. Neither phenomenon would be possible if the vasotonic and the vasoreflex mechanism were identical.

Southern Medical Journal, Birmingham, Ala.

December, VIII, No. 12, pp. 1019-1122

19 *Abscess of Liver. J. B. Elliott, Jr., New Orleans.
20 Renal Infections, with Special Reference to Distant Foci. C. M. Nice, Birmingham.
21 Detection and Diagnosis of Gallstones by Roentgen Ray. G. M. Niles, Atlanta, Ga.
22 Disease — Neglected Factor in History. J. W. Fries, Winston-Salem, N. C.
23 *Test of Diet in Prevention of Pellagra. J. Goldberger, C. H. Waring and D. G. Willets, Washington, D. C.
24 *Treatment of Pellagra by Diet. D. G. Willets, Washington, D. C.
25 Sanitation of Vera Cruz, Mexico, During American Occupation. W. D. Wrightson, Washington, D. C.
26 Full-Time Health Officer Work in Walker County (Ala.). C. A. Grote, Jasper.
27 Local Anesthesia Laparotomy for Forty-Three-Pound Multilocular Ovarian Cyst in Patient Seventeen Years of Age. H. P. Cole, Mobile.
28 Importance of Faucial Tonsil as Portal of Entry in Tuberculous Cervical Adenitis; Twenty-Nine Cases. B. C. Willis, Richmond, Va.
29 Vocal Strain from Laryngologist's Standpoint; Its Causes and Prevention. W. A. Wells, Washington, D. C.

19. **Abscess of Liver.**—While the ameba histolytica was found by Elliott in only 21.5 per cent. of 116 cases, he believes that more correct methods of investigation would show it to be the primal cause in at least 80 per cent. of the cases. The most constant symptoms are pain in region of the liver, loss of weight and increased leukocyte count. The aspirating needle used for exploration should be at least 5 inches in length. Exploratory laparotomy is justifiable in doubtful cases. Emetin should be used in all cases of hepatic abscess as a regular postoperative measure. Elliott urges that all recurring diarrhea in the South should be studied carefully. He is of the belief that many of these cases are amebic in origin.

23 and 24. Abstracted in THE JOURNAL, December 11, p. 2114.

FOREIGN

Titles marked with an asterisk (*) are abstracted below. Single case reports and trials of new drugs are usually omitted.

Archives of Radiology and Electrotherapy, London

November, xXX, No. 6, pp. 175-208

1 *New Therapeutic Roentgen Ray Localizer. R. Knox and A. St. George Caulfeild.
2 Photographic Action of Radio-Active Sources. W. Makower.

3 Fluorescent Screen Localization by Parallax Method. A. C. Jordan.
4 *Roentgenograms to Illustrate Velocity of Rifle Bullet as Determining Factor in Extent of Injury. G. Vilvandre.

1. New Therapeutic Roentgen Ray Localizer.—The principle employed by Knox and Caulfeild is that of the rotating tube, making a circle on the surface and focusing the sheaf of rays on a point in the interior whose depth is determined by the angle at which the tube box is fixed. The chief field of action for the centering device is in the treatment of malignant disease. It will be possible to attack a growth from all aspects and the maximum dose to be administered at will to selected areas of the growth.

4. Roentgenograms to Illustrate Velocity of Rifle Bullet.—The series of cases reported by Vilvandre illustrates the point that the damage done by rifle bullets is dependent on the velocity of the missile rather than on the texture of the bone.

British Medical Journal, London

November 20, II, No. 2861, pp. 737-768

5 Clinical Aspects of Typhus. P. C. T. Davy and A. J. Brown.
6 Recrudescence of Local Sepsis in Completely Healed Wounds. R. H. J. Swan and K. Goadby.
7 Treatment of Wounds in War. J. Tissot.
8 Tartar Emetic in Kala-Azar. P. Mackie.
9 Bilharziosis in Natal. F. G. Cawston.
10 Auscultation of Heart of Recruit. J. K. Fowler.

Journal of Tropical Medicine and Hygiene, London

November 15, XVIII, No. 22, pp. 253-264

11 *Notes on Certain Insecticides. A. Castellani and T. W. Jackson.
12 *Inoculation of Smallpox as Prophylactic Measure as Practiced by Natives at Djen in Nigeria. H. A. Foy.
13 Schistosomiasis in Natal. F. G. Cawston.
14 Case of Oriental Sore Treated by Antimonium Tartaratum (Tartar Emetic) Locally. G. C. Low.

11. Insecticides.—In regard to solid and liquid insecticides, the substances which Castellani and Jackson have found to be deleterious to body-lice are, in the order of their efficiency: Kerosene oil, petrolatum, guaiacol, anise preparations, iodoform, compound solution of cresol and similar preparations, phenol solution, naphthalene, camphor. Pyrethrum has a feeble action on lice, while boric acid, sulphur, mercuric chlorid and zinc sulphate, when used in powder form, have apparently no action whatever. As regards bedbugs, kerosene oil is the best insecticide. Next to it comes guaiacol, one of the most active drugs of those the authors have tried.

Substances which are powerful licecides may have little or no action on bedbugs, and vice versa. For instance, iodoform, which kills lice within ten to fifteen minutes, has practically no deleterious action on bedbugs, which may live for more than twenty-four hours when exposed to it. It has also little effect on fleas. Pyrethrum, on the other hand, has a much more powerful action on bedbugs than on lice.

For use against lice on a large scale, as among troops and prisoners, perhaps the best insecticide powder is naphthalene. This substance has a lower licecide action than kerosene oil, guaiacol, iodoform and anise preparations, but it has a less displeasing odor than the first three named. In stored blankets and clothing it is also practicable and of use, as frequently lice are found on the clothing and blankets stored through the summer. Naphthalene is useful also for its well-known deterrent action on moths. Castellani and Jackson are speaking here of insecticide powders. As regards liquid insecticides, the American Red Cross Sanitary Commission gave sanction to kerosene by its daily use on troops and prisoners. For the better class of patients in practice a menthol powder is to be preferred to naphthalene in most cases, as its odor is not displeasing, while it is repellent to mosquitoes, in addition to lice and fleas. Such powder is especially useful in summer in hot countries, as it has a cooling effect on the skin and often prevents a prickly heat.

12. Inoculation of Smallpox.—The points of interest in Foy's paper are: (a) Of a mixed population 80 per cent. (male, female and children) inoculated with the virus of smallpox from a case of discrete smallpox developed a local reaction, the comparative percentage so far as adults and children go being fairly equal. (b) Of those inoculated, 43.3 per cent. (mixed population) developed smallpox; adults 30.9 per cent. and children 48.7 per cent. (c) Fifty-three per cent. of those that showed a local reaction at seat of inoculation developed smallpox. (d) Adults 38.8 per cent. (male and female) and 48.7 per cent. children out of (c) developed smallpox. (e) Both from (b) and (d) the figures show a much higher degree of susceptibility of children as compared with adults when inoculated with the disease. (f) The mortality in twenty-six cases that developed the disease out of sixty inoculated was nil; mortality, however, occurred among other inoculated cases, but it was not possible to get definite figures of mortality relative to the number inoculated and to the number that developed a local reaction. (g) Incubation period of infection naturally acquired is eleven days. In three inoculated cases the eruption appeared on the ninth day after inoculation, so that the disease began on the seventh day and incubation period is shortened as a result of inoculation. (h) Nature of attack resulting from inoculation. Of the twenty-six cases that developed smallpox, six were badly marked, showing a fairly acute attack of discrete smallpox; the remaining twenty had slight marking as an indication of a mild attack.

Annales de Médecine, Paris

July, II, No. 4, pp. 315-440

15 Paratyphoid Fevers. C. Achard.
16 Traumatism as a Factor in Pleuro-Pulmonary Tuberculosis. G. Brouardel and L. Giroux.
17 *Cholera; One Hundred Cases. G. Delamare.
18 Blue-Staining Granules in the Mononuclears in Normal and in Leukemic Blood. (Les granulations azurophiles des mononucléaires.) C. Aubertin and H. Chabanier.
19 *The Cardio-Peritoneal Syndromes in Typhoid Fever. L. Bernard and J. Paraf.

17. Cholera.—Delamare's study is based on 100 cases of which he had charge in Constantinople in 1912. These patients were nearly all otherwise healthy; there was a history of malaria in only ten. The general mortality during the epidemic was 47 per cent., but in his cases it was only 30 per cent. His main reliance was on baths, and heat applied to the feet and hands, with saline infusion and heart tonics. Yoghurt and rice were the main diet during convalescence, and there were no gastro-intestinal after-effects.

19. The Heart and Peritoneum in Typhoid Fever.—Bernard and Paraf call attention to the symptoms of weakness on the part of the heart and of irritation of the peritoneum before there is actual peritonitis. With both the cardiac asthenia and the preperitonitic syndrome, we have meteorism, small, rapid pulse and cyanosis or pallor of the face or the leaden tint of peritonitis, but the heart sounds reveal the weakening of the heart action, while the muscular defense in the abdominal wall calls attention to the trouble below, thus differentiating the two syndromes. When the two are associated death generally ensues, even without actual development of peritonitis or true heart collapse. They describe some typical cases in which the cardiac or the peritoneal syndrome preceded the other. The measures required for one are contraindicated by the other. In the preperitonitic stage prompt operative treatment may be the only means to ward off the impending peritonitis. In their one case of recovery they varied the treatment according to which syndrome predominated at the moment, changing from baths to ice or heart tonics as the indications varied.

Archives des Maladies du Cœur, etc., Paris

November, VIII, No. 11, pp. 361-436

20 *Nature and Cause of Accidents from Resorption in Edema. H. Vaquez.
21 *Typhoid Appearing as a Hemorrhagic Syndrome. J. Milhit and H. Chabanier.

20. Disturbances from Absorption in Edema.—Vaquez refers to the dizziness, headache, dyspnea, general weakness and other symptoms sometimes noted when edematous fluid is being absorbed, before the fluid has been thrown off by the kidneys or evacuated otherwise. Swelling of the joints, cramps in the calf of the leg, somnolency, stupor or insomnia with agitation, vomiting or convulsions, may also be encoun-

tered, but they subside as a rule as soon as ample diuresis is established. In one of his cases the congestion of the face was so intense that some of the capillaries seemed to have ruptured. Andral and Kostkevitch have each reported negative necropsy findings in a case of fatal accidents from this cause. Vaquez reviews the data on the subject and agrees with those who regard the disturbances as analogous to serum sickness. As the dropsical accumulations become mobilized and are taken up into the blood they induce actual anaphylaxis. The phenomena of this auto-anaphylaxis also include the dropping of the arterial blood pressure and considerable but transient albuminuria.

The third criterion of the "anaphylactic shock"—leukopenia—has not been sought for systematically to date, but de Jong and Bezançon reported a leukopenia like that of anaphylactic shock in a case in which part of a pleural effusion was siphoned out, but quite a quantity still left. Vaquez noted in one case a marked drop in arterial tension after diuresis amounting to 18 liters. When the edema fluid is drained away through the skin, there is no chance for the conflict between the albuminoids in the fluid and the colloids in the blood, which causes the phenomena. The latter are more frequent in the elderly because their kidneys are less able to cope with the task of eliminating the mobilized fluids. The anaphylactic phenomena are of course most liable to occur and most pronounced during the period between the mobilization of the dropsical accumulations and the liberating diuresis. Analysis of the phenomena reveals that they are essentially the same as those induced by Richet in his experimental research on anaphylaxis and those recorded by Widal in clinical paroxysmal hemoglobinuria.

21. **Hemorrhagic Onset of Typhoid.**—The patient was a young man who complained of headache and pain in the lumbar region and the next day he voided red urine. This suggested scarlet fever and he was sent to the isolation hospital, but the absence of sore throat and eruption, and a history of scarlet fever in childhood finally excluded this disease. The intestines, liver and lungs seemed to be normal, but the agglutination test finally pointed to typhoid. Hemorrhagic vesicles developed on the body, with epistaxis, and spitting of blood, till death the twenty-fourth day.

Beiträge zur Klinik der Tuberkulose, Würsburg

XXXIII, No. 2, pp. 111-220. Last indexed Jan. 30, 1915, p. 472

22 Therapeutic Induced Pneumothorax in Pulmonary Tuberculosis. W. Zinn and H. Geppert.

23 Serologic Tests to Distinguish Between Tuberculous Bronchial Glands and Pulmonary Tuberculosis. (Versuch zur Abgrenzung der reinen Bronchialdrüsentuberkulose von der Lungentuberkulose mit Hilfe der Abderhaldenschen Abwehrfermente.) F. Oeri.

24 Lime in Treatment of Tuberculous Bronchial Glands. (Einige röntgenologische und klinische Beobachtungen bei Kalkbehandlung der Bronchialdrüsentuberkulose.) A. Wersen.

June, No. 3, pp. 221-266

25 Spread of Tuberculosis in the Male Genital System. (Ueber die Ausbreitung der Tuberkulose im männlichen Genitalsystem.) C. Kraemer.

July, No. 4, pp. 267-412

26 Pulmonary Tuberculosis and New Dualistic Bases for Actually Specific Treatment. H. Kronberger.

Mitteilungen a. d. Grenzgeb. der Med. und Chir., Jena

XXVIII, No. 5, pp. 749-900. Last indexed Aug. 21, p. 749

27 *Typhoid from Surgical Standpoint. (Chirurgisches über Typhus; schwierigere Fälle.) B. Riedel.

28 *Dissolved Albumin in Stomach Content as Sign of Cancer. (Die diagnostiche Bedeutung der Eiweissbestimmung im Mageninhalt nach Salomon.) H. Zoeppritz.

29 Importance of the Functioning of the Antrum Pylori in Prevention and Treatment of Postoperative Peptic Ulcer. (Bedeutung der Funktion des Antrum pylori für die Magenchirurgie.) H. Schur and S. Plaschkes.

30 Influencing of Leukocyte Picture by Iodin. (Ueber die Beeinflussung des weissen Blutbildes durch Jod.) J. Bauer.

31 Gunshot and Shell Wounds of the Chest. (Ueber Chylopneumothorax durch Schussverletzung nebst Bemerkungen über Lungenschüsse.) J. Frohmann.

32 Roentgenoscopy of Motor Function of Diseased Stomach. (Zur Radiologie der Bewegungsvorgänge am kranken Magen.) H. Fischer.

33 *Transient Glucosuria with Fractures. (Glykosurie und Diabetes bei chirurgischen Erkrankungen. I.) G. E. Konjetzny and W. Weiland.

34 Inhibiting Action of Malachite Green and Kristallviolett on Experimental Septicemia in Guinea-Pigs. (Wirkung einiger Anilinfarbstoffe auf experimentell erzeugte Septikämie bei Tieren.) G. Hofer.

27. **Surgical Aspects of Typhoid Complications.**—Riedel analyzes here his experiences with forty operative typhoid cases, mostly tardy complications. He remarks that the number of such complications is probably larger than has been suspected hitherto, as the connection with typhoid years before has often been overlooked. Complications in soft parts are particularly dangerous, especially peritonitis from diapedesis. Typhoid appendicitis is controlled comparatively easily, and typhoid cholecystitis still more readily. Bone tissue is vitally less important than soft part tissues, and has unlimited capacity for regeneration. Hence typhoid foci in bones are not much to be feared unless they are located at particularly unfavorable points. Typhoid foci in joints heal favorably if operated on at the proper time. One boy of 14, seven months after appendicectomy, suddenly developed symptoms of peritonitis ascribed to the stump of the appendix. Laparotomy the third day confirmed the diffuse peritonitis, but no cause for it could be detected until necropsy next day revealed flat typhoid ulcers in the intestines, the serosa above absolutely intact. This case suggests that a symptomless typhoid may be responsible for many cases of so-called spontaneous peritonitis. In one case he mistook ordinary swollen glands back of the apparently sound appendix for typhoid appendicitis, and Thomas and Frazier have reported eight cases of typhoid suppuration in mesenteric glands.

Another patient was a man of 35 with multiple posttyphoid fistulas near the anus beyond operative repair. One woman with senile paranoia at 57 had peritonitis from diapedesis and typhoid was assumed. The intestines were found sound but typhoid bacilli were cultivated from the gallbladder. One patient with purulent typhoid thrombophlebitis of the internal saphenous vein was saved by its extirpation. Thrombosis followed in the external saphenous vein but no suppuration. In another case thrombosis in the femoral vein in the course of typhoid was followed four years later by thrombophlebitis in the external saphenous and the fever persisted for weeks after extirpation of the vein.

The costal cartilages were the seat of the skeletal typhoid process in eleven of twenty-three cases, and the tibia in six. The process healed smoothly, as a rule, after resection. The most serious were typhoid foci in the costal arch. He had five such cases, and remarks that one can be extravagant in resecting under these conditions as repair proceeds promptly and thoroughly when there is no infection. In infected cases the operation has to be frightfully radical, and the perichondrium grows only bone, not cartilage. In his joint cases, the interval since the typhoid was twelve years in the case of a man of 44 who had had an osteomyelitic process in the hip joint for a year. It healed after resection. Puncture of the hip joint in another case, in a boy of 16, brought typhoid bacilli, and recovery was soon complete under drainage alone. In two other cases the knee or hip joint developed deforming arthritis after the typhoid joint trouble.

28. **Dissolved Albumin in Stomach Content as Sign of Cancer.**—Zoeppritz points out that the presence of dissolved albumin in the fasting stomach does not decide between ulcerative and nonulcerative processes, but the absence of albumin renders the assumption of malignant disease highly improbable. Stagnation of stomach contents and lack of the normal acid favor the appearance of albumin in the stomach washings but do not influence its production. Albumin may sometimes be found in the clinically normal stomach, but it occurs more frequently with chronic gastric trouble. His tabulated records of forty-eight operative cases of gastric cancer showed a positive response to the Esbach test in all but 8 cases, and there was no free acid in 7 in this group and very little in the remaining case. His tables show further a positive reaction in 14 of 21 operative cases of gastric ulcer and in 5 of 6 without an operation;

also in 5 of 6 operative cases of chronic gastritis and in 8 of 8 nonoperative cases; in 4 of 7 other operative stomach affections and in 5 of 5 nonoperative; in 14 of 16 operative abdominal affections and in 12 of 12 in which no operation was attempted. In one case an extensive cancer in the submucosa had irritated the mucosa and caused secretion of mucin and nuclein, which gave the positive albumin reaction, although there was scarcely any ulceration and this was close to the gaping pylorus. The various groups are tabulated in detail and the reaction compared to other tests for cancer. In 135 cases of gastric cancer at Kiel occult or visible blood was found in 95 per cent.; there was emaciation in 90 per cent.; anacidity in 89; dissolved albumin in 83; lactic acid in 67; long bacilli in 64 and a palpable tumor also in 64 per cent. The albumin reaction was positive, if at all, very soon after the first symptoms appeared. The test for albumin is simple and easy if the stomach motor function is normal, but with impaired evacuation it is a tedious matter to rinse the stomach clean, and the slightest erosion of the stomach walls nullifies the findings of the test.

33. **Transient Glucosuria with Fractures.**—Konjetzny and Weiland report from the surgical clinic at Kiel 34 cases of fracture in which there were no traces of traumatic glucosuria; 3 in which the examination on account of the accident revealed hitherto unsuspected diabetes; and 24 of alimentary glucosuria after fracture of the leg or arm. The sugar content of the blood was recorded in 36 cases and found abnormally high in 31. Of the total 83 fracture cases there was no tendency to glucosuria in 48.1 per cent., while in 40.9 per cent. there was actual traumatic glucosuria, and in 7.2 per cent. alimentary glucosuria. The traumatic glucosuria is transient and there is no polyuria or polydipsia, but it is accompanied by hyperglycemia. They regard it as a transient central lesion, like the sugar puncture; it may be in the nature of fat embolism.

Policlinico, Rome

November 7, XXII, No. 45, pp. 1505-1536

35 Hydatidiform Mole in Mother and Daughter. (Mola vescicolare in parto bigemino teratologico.) E. Iraci.
36 Scarlet Fever. P. Timpano.

November 14, No. 46, pp. 1537-1568

37 *Hemoglobinuria from Beans. (Il favismo.) A. Gasbarrini.
38 Workmen's Compensation and Safety Appliances. (La profilassi degli infortuni e gli interessi degli operai.) G. Dragotti.
39 Subcutaneous Nodules in Acute Articular Rheumatism. P. Ercolani.

37. **Hemolytic Jaundice from Beans.**—Favism, from *fava*, "bean," is the name given in Italy to an acute febrile anemia with jaundice and hemoglobinuria which is not uncommon there, and is ascribed to the eating of fresh, raw or dried and cooked beans or smelling the blossoms of bean plants. Gasbarrini accepts it as a morbid entity, the result of acute toxic hemolysis. It was mentioned by Herodotus and by numerous Italian writers in the last century, but Fermi (1905) was the first to apply experimental research in the study of favism. His conclusions favored the assumption of acute toxic action of beans in the predisposed. In the very young it is liable to prove rapidly fatal. It is known only where beans are cultivated on an extensive scale, occurs usually in the spring, and Fermi noticed a hereditary character in 20 per cent. of his cases, sometimes through several generations. The inherited predisposition may not become manifest till adult life. Infants and the elderly generally escape. Quinin has been excluded as a factor by six Italian physicians who have made a special study of this question. The Wassermann reaction has always been found negative in favism, and the history of the frequent cases also excludes syphilis as a factor. Fermi has reported that in 1,211 cases in Sardinia, 752 were ascribed to ingestion of beans and the others to inhalation of the odor or pollen. Tomaselli has reported cases in which the disturbances occurred immediately after passing through a field of beans in flower. Montano had one patient affected anew whenever he inhaled the odor of bean blossoms or passed near a pile of fresh beans. Nurslings can also be affected when the predisposed mother eats beans.

The affection does not seem to be contagious and there is no period of incubation, the disturbances coming on at latest in a day or so after ingestion of the beans or in from two to six hours after inhalation. Acute fever, black urine, intense anemia and jaundice distinguish favism and there may be a rigor, vomiting and diarrhea. No one has been able to isolate from beans any toxic substance that might be responsible for this toxic hemolysis; some believe that a fungus on the beans is responsible for the symptoms. Others accept a bacterial origin, but no evidence has been presented to sustain this assumption. There does not seem to be any idiosyncrasy to quinin in persons affected with or predisposed to favism. With paroxysmal hemoglobinuria there is not the extreme prostration characteristic of favism, but there is a close resemblance between the latter and Plehn's hemoglobinuric icterus in all its forms, from the abortive and mild to the grave, the fulminating and the hemorrhagic. Even the blood picture seems to be identical. Echinococcus disease of the liver is liable to be mistaken for favism or vice versa, as both are prevalent in the same regions. The cadaver of one child with acute favism showed merely changes indicating some old liver and spleen trouble of obscure cause. This is the only complete necropsy on record. As soon as the hemoglobinuria is past, recovery proceeds rapidly. Some of the predisposed suffer whenever they are exposed to the assumed cause; in others, one attack seems to confer immunity for years or permanently. In Fermi's statistics the mortality was 8 per cent. It is highest in children and the disease seems to be especially grave in certain seasons. Treatment can be only symptomatic. Injections of horse serum and of cholesterin and calcium chlorid by the mouth have been tried but without decisive results.

Hygiea, Stockholm

LXXVII, No. 20, pp. 1185-1264

40 *Abuse of Tobacco from the Medical Standpoint. (Om tobaksmissbruket från medicinsk synpunkt.) C. F. Höckert.

40. **Abuse of Tobacco from the Medical Standpoint.**—This issue of *Hygiea* has an unusually good portrait of Ehrlich, with a ten-page tribute to his work. The usual comment on the picture, however, is that Ehrlich is shown without his inevitable cigar, and it is a curious coincidence that the rest of the number is devoted to the "Abuse of Tobacco." Its use and abuse are discussed from the historical and geographical as well as the medical standpoint. Some recent chemical and experimental research is described and some of the new books on the subject are reviewed. They include Bresler's "Tabakologia medicinalis" (1911) and von Frankl-Hochwart's "Nervous Affections of Tobacco Smokers" (1912).

Ugeskrift for Læger, Copenhagen

November 11, LXXVII, No. 45, pp. 1737-1784

41 *Pronounced Lesions in Untreated Syphilis with Negative Wassermann Reaction. A. L. Fønss.

41. **Manifest Syphilis, Untreated, with Negative Wassermann Reaction.**—Fønss has encountered 243 cases of syphilis in which there had been no attempt at treatment. In 172 the lesions were those of the secondary stage of the disease and in 20 of the tertiary stage. Of these two groups with manifest syphilitic lesions, there was no reaction to the Wassermann test in 10 of the 172 secondary cases nor in 4 of the 20 extensive tertiary cases nor in 11 of the 51 cases with tertiary lesions restricted to a single small area. The negative response may veer to positive or vice versa within a few days, so that repetition of the test in dubious cases is advisable after the reactivation liable when treatment is instituted. Fønss remarks that a positive reaction is extremely important with latent syphilis and also in dubious cases, although, he reiterates, we must not forget that it is never an "organ diagnosis." A repeatedly negative reaction, he adds, is not particularly important for the diagnosis, especially when the patient has been taking recent treatment. His experience shows further that even with untreated syphilis a negative reaction is not uncommon, nearly 10 per cent. in his cases (25 in 243). These negative cases are described in detail and compared with those published by others.

JOURNALS INDEXED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT JULY-DECEMBER, 1915

The following journals have been indexed in the Current Literature Department of THE JOURNAL during the past six months. Any of the foreign journals, except those starred, will be lent by THE JOURNAL to subscribers in the United States and to Fellows of the American Medical Association for a period not exceeding three days. Only one journal may be borrowed at a time. Requests for periodicals should be addressed to the Library of the American Medical Association and six cents in stamps should be enclosed. This covers the average expense of mailing a journal. Domestic journals can be obtained by sending the approximate amount direct to the respective publishers. Thus most of the journals indexed are accessible to the general practitioner, no matter where he may be located.

Albany Medical Annals. M. $2. 170 Washington Ave., Albady, N. Y.
American Journal of Anatomy. Bi-m. $5. 36th St. and Woodland Ave., Philadelphia.
American Journal of Diseases of Children. M. $3. American Medical Association, 535 N. Dearborn St., Chicago.
American Journal of Insanity. Q. $5. Johns Hopkins Press, Baltimore.
American Journal of the Medical Sciences. M. $5. Lea & Febiger, 706 Sansom St., Philadelphia.
American Journal of Obstetrics and Diseases of Women and Children. M. $5. William Wood & Co., 51 Fifth Ave., New York.
American Journal of Orthopedic Surgery. Q. $3. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia.
American Journal of Physiology. M. $5. Johns Hopkins Medical School, Baltimore, Md.
American Journal of Public Health. M. $3. 755 Boylston St., Boston.
American Journal of Roentgenology, M. $5. 67 E. 59th St., New York.
American Journal of Tropical Diseases and Preventive Medicine. M. $2. P. O. Drawer 1110, New Orleans, La.
Annales de gynécologie et d'obstétrique. M. 22 francs. Paris.
Annales de médecine. M. 23 francs. Paris.
Annals of Ophthalmology. Q. $4. Mermod-Jaccard Bldg., St. Louis.
Annals of Otology, Rhinology and Laryngology. Q. $4. Mermod-Jaccard Bldg., St. Louis.
Annals of Surgery. M. $5. J. B. Lippincott Co., E. Washington Square, Philadelphia.
Annals of Tropical Medicine and Parasitology. Q. $5. Liverpool.
Archiv für Gynäkologie. Irregular. Price varies. Berlin.
*Archiv für Kinderheilkunde. Irregular. 15 marks. Stuttgart.
Archiv für klinische Chirurgie. Irregular. Price varies. Berlin.
Archiv für Verdauungs-Krankheiten. Bi-m. 24 marks. Berlin.
Archives of Diagnosis. Q. Rebman Co., 141 W. 36th St., New York.
Archives of Internal Medicine. M. $4. American Medical Association, 535 N. Dearborn St., Chicago.
*Archives de médecine des enfants. M. 18 francs. Paris.
*Archives des maladies de l'appareil digestif et de la nutrition. M. 14 francs. Paris.
Archives des maladies du cœur, des vaisseaux et du sang. M. 17 francs. Paris.
Archives mensuelles d'obstétrique et de gynécologie. M. 25 francs. Paris.
Archives of Ophthalmology. Bi-m. $5. G. P. Putnam's Sons, 2 W. 45th St., New York.
Archives of Pediatrics. M. $3. E. B. Treat & Co., 241 W. 23d St., New York.
Archives of Radiology and Electrotherapy. M. $4.50. London.
Arizona Medical Journal. M. $2. Phoenix, Ariz.
*Beiträge zur klinischen Chirurgie. M. Price varies. Tübingen.
Berliner klinische Wochenschrift. W. 24 marks. Berlin.
Boston Medical and Surgical Journal. W. $5. 126 Massachusetts Ave., Boston.
Brain: A Journal of Neurology. Irregular. $4. London.
Brazil Medico. W. 20 milreis. Rio de Janeiro.
Bristol Medico-Chirurgical Journal. Q. $3.
British Journal of Children's Diseases. M. $5. London.
British Journal of Surgery. Q. $6.50. William Wood & Company, 51 Fifth Ave., New York.
British Journal of Tuberculosis. Q. $1.25. G. E. Stechert & Co., 151 W. 25th St., New York.
British Medical Journal. W. $8.50. London.
Bulletin de l'Académie de médecine. W. 20 francs. Paris.
Bulletin of the Johns Hopkins Hospital. M. $2. Baltimore.
Bulletin of the Lying-in Hospital of the City of New York. Irregular. $1. 23 E. 93d St., New York.
Bulletin of the Medical and Chirurgical Faculty of Maryland. M. $0.25. 1211 Cathedral St., Baltimore.
California State Journal of Medicine. M. $1. Butler Bldg., San Francisco.
Canadian Medical Association Journal. M. $5. 145 Wellington St., W., Toronto.
Centralblatt für die Grenzgebiete der Medizin und Chirurgie. Irregular. 22 marks. Jena.
China Medical Journal. Bi-m. $4. Shanghai.
Cleveland Medical Journal. M. $2. 2318 Prospect Ave., Cleveland.
Colorado Medicine. M. $2. Majestic Bldg., Denver.
Correspondenz-Blatt für schweizer Aerzte. W. 22 francs. Basel.
Delaware State Medical Journal. M. $1. Wilmington.
Deutsche medizinische Wochenschrift. W. 32 marks. Berlin.
*Deutsche Zeitschrift für Chirurgie. M. Price varies. Leipsic.
*Deutsches Archiv für klinische Medizin. Irregular. Price varies. Leipsic.
Dublin Journal of Medical Science. M. $5.
Edinburgh Medical Journal. M. $6.
Gazzetta degli ospedali e delle cliniche. Semi-w. 25 francs. Milan.
Glasgow Medical Journal. M. $5.
Grèce médicale. Semi-m. 12 francs. Athens.
Hospitalstidende. W. 27.5 kronen. Copenhagen.
Hygiea. M. $5. Stockholm.
Illinois Medical Journal. M. $2. 3338 Ogden Ave., Chicago.
Indian Journal of Medical Research. Q. $2.50. Calcutta.
Indian Medical Gazette. M. $5. Calcutta.
Jahrbuch für Kinderheilkunde. M. 36 marks. Berlin.
Journal d'urologie médicale et chirurgicale. M. 40 francs. Paris.
Journal of Abnormal Psychology. Bi-m. $4. R. G. Badger, 194 Boylston St., Boston.
Journal of the American Medical Association. W. $5. 535 N. Dearborn St., Chicago.
Journal of the Arkansas Medical Society. M. $1. 810 State Bank Bldg., Little Rock, Ark.
Journal of Biological Chemistry. M. $3. 2419 Greenmount Ave., Baltimore.
Journal of Cutaneous Diseases. M. $5. Rebman Company, 141 W. 36th St., New York.
Journal of Experimental Medicine. M. $5. Rockefeller Institute for Medical Research, 66th St. and Avenue A, New York.
Journal of the Florida Medical Association. M. $1.00. 334 St. James Bldg., Jacksonville, Fla.
Journal of the Indiana State Medical Association. M. $1. 219 W. Wayne St., Fort Wayne, Ind.
Journal of Infectious Diseases. Bi-m. $5. 629 S. Wood St., Chicago.
Journal of Iowa State Medical Society. M. $2. Des Moines, Ia.
Journal of Kansas Medical Society. M. $2. 303 Commerce Bldg., Topeka, Kan.
Journal of Laboratory and Clinical Medicine. M. $3. C. V. Mosby Company, St. Louis.
Journal of Laryngology, Rhinology and Otology. M. $5. London.
Journal of Maine Medical Association. M. $2. Portland, Maine.
Journal of Medical Association of Georgia. M. $1. Harison Bldg., Augusta, Ga.
Journal of Medical Research. Bi-m. $4. 240 Longwood Ave., Boston.
Journal of Medical Society of New Jersey. M. $2. 12 Cone St., Orange, N. J.
Journal of Michigan State Medical Society. M. $3.50. 91 Monroe Ave., Grand Rapids, Mich.
Journal of Missouri State Medical Association. M. $2. 3525 Pine St., St. Louis.
Journal of Nervous and Mental Diseases. M. $5. 64 W. 56th St., New York.
Journal of Obstetrics and Gynecology of the British Empire. M. $6.25. London.
Journal of Oklahoma State Medical Association. M. $2. Muskogee.
Journal of Outdoor Life. M. $1. 289 Fourth Ave., New York.
Journal of Parasitology. Q. $2. Urbana, Ill.
Journal of Pathology and Bacteriology. Q. $5.50. Cambridge, Eng.
Journal of Pharmacology and Experimental Therapeutics. Bi-m. $5. 2419 Greenmount Ave., Baltimore.
Journal of the Royal Naval Medical Service. Q. $1. London.
Journal of Sociologic Medicine. Bi-m. $3. 52 N. Fourth St., Easton, Pa.

W.—Weekly; M.—Monthly; Semi-m.—Semi-monthly; Bi-m.—Bi-monthly; Q.—Quarterly. *Cannot be loaned.

Journal of South Carolina Medical Association. M. $2. Anderson, S. C.
Journal of Tennessee State Medical Association. M. $2. 306 First National Bank Bldg., Nashville, Tenn.
Journal of Tropical Medicine and Hygiene. Semi-m. $5. London.
Journal-Lancet. Semi-m. $2. 839 Lumber Exchange, Minneapolis.
Kentucky Medical Journal. M. $2. State and Twelfth Sts., Bowling Green, Ky.
Lancet. W. $8. London.
Lancet-Clinic. W. $3. University Bldg., 648 Main St., Cincinnati.
Laryngoscope. M. $5. 3858 Westminster Place, St. Louis.
Lyon chirurgical. M. 25 francs.
Lyon médical. W. 20 francs.
Medical Record. W. $5. W. Wood & Co., 51 Fifth Ave., New York.
Medizinische Klinik. W. 32 marks. Berlin.
Military Surgeon. M. $3.50. Seventh and B Streets, S. W., Washington, D. C.,
Mitteilungen aus den Grenzgebieten der Medizin und Chirurgie. Irregular. 25 marks. Jena.
Mitteilungen aus der medizinischen Fakultät der Kaiserlichen Universität zu Tokyo. Irreg. Price varies. Tokio.
Modern Hospital. M. $3. Metropolitan Bldg., St. Louis.
Monatsschrift für Geburtshülfe und Gynäkologie. M. 42 marks. Berlin.
Monatsschrift für Kinderheilkunde. M. 20 marks. Leipsic.
Münchener medizinische Wochenschrift. W. 32 marks. Munich.
Nederlandsch Tijdschrift voor Geneeskunde. W. 10.50 florins. Amsterdam.
New Mexico Medical Journal. M. $2. P. O. 23, Las Cruces, N. M.
New Orleans Medical and Surgical Journal. M. $2. 1551 Canal St., New Orleans.
New York Medical Journal. W. $5. A. R. Elliott Publishing Co., 66 W. Broadway, New York.
New York State Journal of Medicine. M. $1. 17 W. 43d St., New York.
*Nordiskt Mediciniskt Arkiv. Irregular. 30 marks. Stockholm.
Norsk Magazin for Lægevidenskaben. M. $5. Christiania.
Northwest Medicine. M. $2. Cobb Bldg., Seattle, Wash.
Ohio State Medical Journal. M. $2. 25 Ruggery Bldg., Columbus, Ohio.
Old Dominion Journal of Medicine and Surgery. M. $2. 116 E. Franklin St., Richmond, Va.
Ophthalmic Record. M. $4. 7 W. Madison St., Chicago.
Ophthalmology. Q. $5. 711 Cobb Bldg., Seattle, Wash.
Paris médical. Tri-m. 16 francs.
Pediatria. M. 12.50 lire. Naples.
Pennsylvania Medical Journal. M. $2. Athens, Pa.
Philippine Journal of Science. Irregular. $7. Manila, P. I.
Policlinico. W. 32 lire. Rome.
Practitioner. M. $6.50. London.
Presse médicale. Semi-w. 15 francs. Paris.
Providence Medical Journal. Bi-m. $1. Francis and Hayes Sts., Providence, R. I.
Public Health Journal. M. $2. York Publishing Co., Lumsden Bldg., Toronto.
Quarterly Journal of Medicine. $6.50. London.
Revue médicale de la Suisse romande. M. 14 francs. Geneva.
Riforma medica. W. 35.50 lire. Naples.
Russkiy Vrach. W. 13 rubles. Petrograd.
Sei-I-Kwai. M. $2. Tokio.
Semana médica. W. $5. Buenos Aires.
Southern Medical Journal. M. $2. 807 Empire Bldg., Birmingham, Ala.
Southwest Journal of Medicine and Surgery. M. $1. El Reno, Okla.
Surgery, Gynecology and Obstetrics with International Abstract of Surgery. M. $10. Surgical Publishing Co., 30 N. Michigan Ave., Chicago.
Svenska Läkaresällskapets Forhandlingar. Irregular. 7.50 kronen. Stockholm.
Texas State Journal of Medicine. M. $1.50. Western National Bank Bldg., Fort Worth, Tex.
Therapeutische Monatshefte. M. 12 marks. Berlin.
Therapie der Gegenwart. M. 14 marks. Berlin.
Tumori. Bi-m. 25 lire. Rome.
Ugeskrift for Læger. W. 20 kr. Copenhagen.
United States Naval Medical Bulletin. Q. $1. Washington, D. C.
Upsala Läkareförenings Förhandlingar. Irregular, 10 kr.
Washington Medical Annals. Bi-m. $1. 2114 18th St., N. W., Washington, D. C.
West Virginia Medical Journal. M. $1. Wheeling, W. Va.
Wiener klinische Wochenschrift. W. 24 marks. Vienna.
Wisconsin Medical Journal. M. $2. Goldsmith Bldg., Milwaukee.
Zeitschrift für Geburtshülfe und Gynäkologie. Irregular. Price varies. Stuttgart.
*Zeitschrift für Kinderheilkunde. Irregular. 18 marks. Berlin.
*Zeitschrift für klinische Medizin. Irregular. 16 marks. Berlin.
*Zeitschrift für Urologie. M. 30 marks. Berlin.
Zentralblatt für Chirurgie. W. 30 marks. Leipsic.
Zentralblatt für Gynäkologie. W. 30 marks. Leipsic.
Zentralblatt für innere Medizin. W. 30 marks. Leipsic.

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EXPLANATION OF THE USE OF THE INDEX

This is an index not only to the reading matter in THE JOURNAL, but also to original articles in the principal medical periodicals of this and other countries. The reading matter appearing in THE JOURNAL is distinguished by the use of **black-faced numerals.**

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "C," Correspondence; "T," Therapeutics; "Ml," Medicolegal; "P," Propaganda for Reform; "ME," Medical Economics; "ab," abstract; the star (*) indicates an "Original Article" in THE JOURNAL.

This is a subject index and one should, therefore, look for the chief word, with the following exceptions: "Book Notices," "Deaths" and "Society Proceedings" are indexed under these titles at the end of the letters "B" "D" and "S." Matter pertaining to the Association is indexed under American Medical Association."

All matter is indexed under the most important word of the heading used in THE JOURNAL, and also under the subject heading. For instance, abscess of the brain will be found under "abscess," as well as under "brain." Such titles as "ocular manifestations, etc.," have been indexed under "Eye." Cross references have been liberally used.

The figures in parentheses refer to the paragraph, the number following to the page in THE JOURNAL.

ABORTION, cause and treatment, *1262

This reference is to an original article in THE JOURNAL, as shown both by the star and by the black-faced numerals indicating the page.

ACID, uric, in blood, Maase-Zondek test for, 1748

This reference as indicated by the black-faced figures, is also in THE JOURNAL, and on turning to page 1748 we find an answer to a question in the Department of Queries and Minor Notes.

ABDOMEN, anomalies of, (149) 1143

In this reference, the (149) indicates that the article is in the Current Literature Department and the fact that the page number is in black-faced type shows that the article is abstracted and discussed in THE JOURNAL. Turning to page 1143, we find (149) refers to an article by F. G. DuBose in the *Southern Medical Journal*, September.

ACETONE bodies in urine, signification of, (24) 831

The fact that in this last reference the page is given in ordinary type indicates that only the title of the article is given. Turning to page 831 we find that the numeral (24) refers to a paper on that subject by B. Derham which appeared in the *Lancet*, July 31.

In the AUTHOR'S INDEX are the names of the authors of articles which have appeared in THE JOURNAL of the American Medical Association and of articles that have been listed from week to week in the Department of Current Medical Literature as having appeared in other journals. The black-faced numerals indicate that the article is in THE JOURNAL, either in full or in abstract. The star (*) preceding the page number indicates an original article.

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SOCIETIES

A.—Association.
Acad.—Academy.
Am.—American.
Coll.—College.
Conf.—Conference.
Cong.—Congress.
Conv.—Convention.
Dist.—District.
Hosp.—Hospital.
Internat.—International.
M.—Medical or Medicine.
Nat.—National.
Phar.—Pharmaceutical.
Phys.—Physicians.
Ry.—Railway.
S.—Society.
Surg.—Surgical, Surgeon or Surgery.

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